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STATE DOCUMENTS

**MONTANA STATE PLAN
FOR ALCOHOLISM
AND
ALCOHOL ABUSE
1975**

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T H E M O N T A N A S T A T E P L A N

For

ALCOHOL ABUSE AND ALCOHOLISM
PREVENTION, TREATMENT, AND REHABILITATION
FISCAL YEAR 1975

Thomas L. Judge, Governor

Compiled and Submitted By

THE MONTANA DEPARTMENT OF HEALTH
AND ENVIRONMENTAL SCIENCES

Legislative Authority: P.L. 91-616, P.L. 93-282

Catalog of Federal Domestic Assistance No. 13-257

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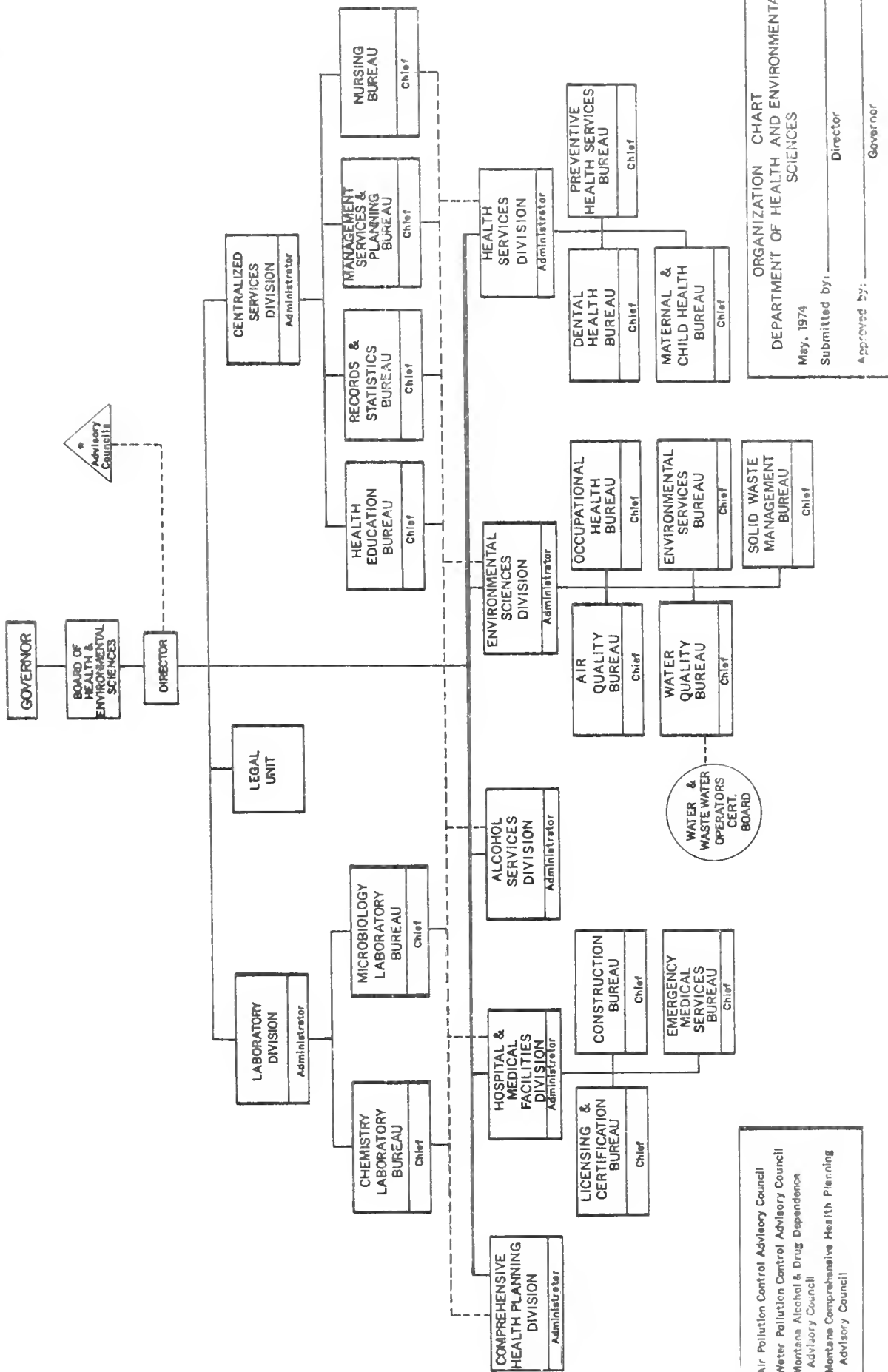
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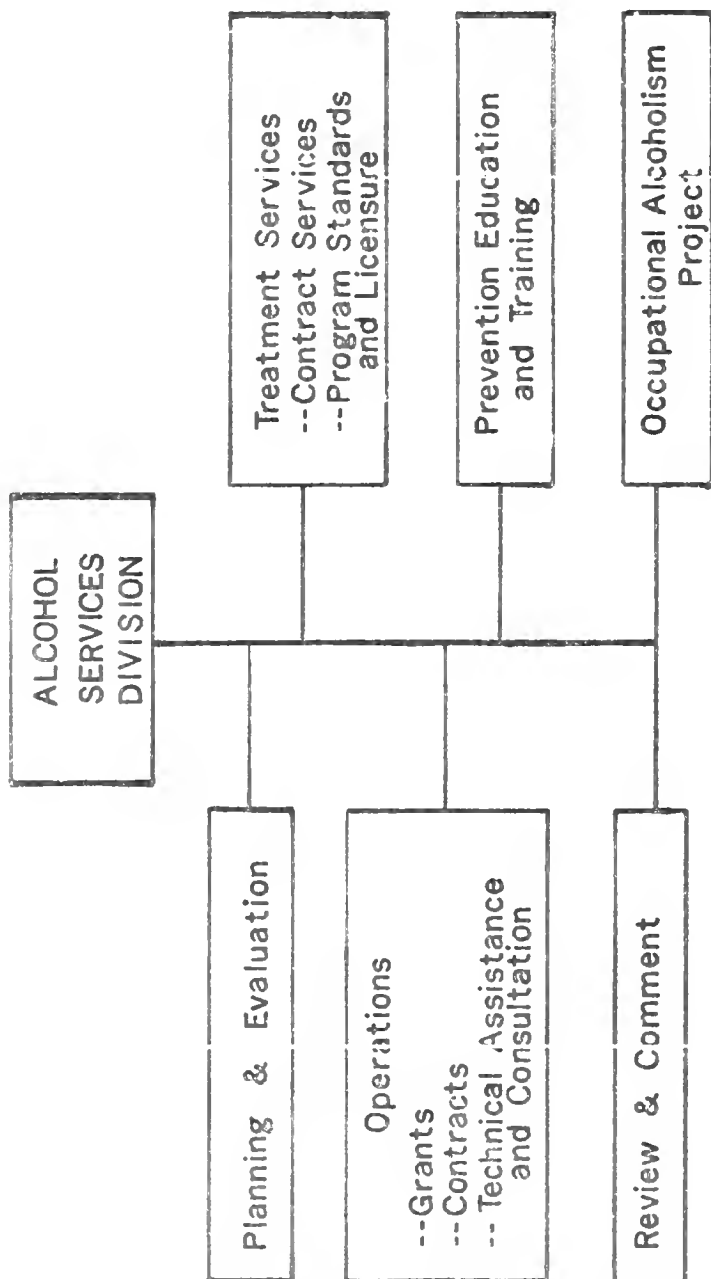
Director

ALCOHOL SERVICES DIVISION *

Robert L. Solomon, M.P.H., Administrator
Paul H. Babbitt, M.A., Consultant
William J. Potts, M.A., Prevention Coordinator
Norma Jean Murphy, R.N., Program Coordinator
Yvonne Sylva, B.A., Program Coordinator
Michael B. FitzPatrick, M.P.H., Consultant
Catherine Siewert (Mrs.), Secretary I
Janice Sampson, Clerk-Steno I
Peggy Baraby (Mrs.), B.S., Accounting Clerk

*See Appendix E - Staff Resumes and Job Classifications





FUNCTIONAL CHART
ALCOHOL SERVICES DIVISION
DEPARTMENT OF HEALTH & ENVIRONMENTAL
SCIENCES

MAY, 1974

ALCOHOL AND DRUG DEPENDENCY ADVISORY COUNCIL

The Montana Alcohol and Drug Dependency Advisory Council is composed of eighteen members and has been developed to address the requirements of P.L. 91-616 and 91-255 which require an advisory council. This Advisory Council is appointed by the Director of the Department of Health and Environmental Sciences with the concurrence of the Governor.

Membership of the Advisory Council consists of eighteen members chosen on the basis of two from each of the five Comprehensive Health Planning "B" areas, two from the Montana Indian cultural region, and six persons at large. Membership of the Advisory Council is reflective of a number of interests and orientations as outlined below:

- American Indian
- Poverty Groups
- Agricultural - Rural
- Alcoholism Program Board Members
- Alcoholism Program Staff
- Law Enforcement
- County Government
- State Government
- Legislature
- Recovering Alcoholics
- Alcoholics Anonymous
- Student
- Elementary Education
- Secondary Education
- Professional Education
- Business
- Professional
- Nursing

All geographic areas of the state are represented, cultural and ethnic minorities are represented as are poverty groups and agencies serving in an advisory function on behalf of poverty and minority groups.

ALCOHOL & DRUG DEPENDENCY ADVISORY COUNCIL

DOROTHY ADAMSON

Administrative Assistant, Blackfeet Tribal Alcoholism Program
Office Phone: 338-7178
Home Address: Box 171
Browning, Montana 59417

JOHN H. ALLEN

Deputy Administrator, Human Resources Division
Office Phone: 449-3420
Home Address: 1140 Vallejo Road
Home Phone: 458-9743
Helena, Montana 59601
Board Member, Alcoholism Rehabilitation Association, Helena

PERCY DeWOLFE

Rancher
Home Address: P. O. Box 250
Home Phone: 338-2449
Browning, Montana 59417
Member of Blackfeet Tribe
Former State Senator

PAUL J. EVERETT, JR.

Trainmaster, Butte, Anaconda & Pacific Railway Co.
Home Address: 1800 Tammany
Home Phone: 563-3826
Anaconda, Montana 59711
Board Member, Community Health Services for Alcoholism, Butte

LARRY FASBENDER

Farmer, Legislator
Asst. Majority Floor Leader, Montana Senate
Home Address: Route 1, Box 23
Home Phone: 264-2425
Fort Shaw, Montana 59443

KATHERINE A. HANRAHAN

Assistant Librarian, Dawson College
Office Phone: 365-3396
Home Address: 710 N. Meade Avenue
Home Phone: 365-2674
Glerdive, Montana 59330

GERALD B. HALL

Lieutenant, Great Falls Police Department

Office Phone: 453-3201

Home Address: Route 1 W., Box 236C

Home Phone: 452-1791

Great Falls, Montana 59401

Consultant to College of Great Falls on Drug Education

Law Enforcement Drug Specialist

MARTHA S. HERLEVI

Legislator, House of Representatives, District #71

Home Address: 221 E. 11th

Home Phone: 446-2871

Red Lodge, Montana 59068

Actively involved in alcoholism program activities in
Montana for a number of years

W. RICHARD IVES

Assistant Professor, Northern Montana College

Office Phone: 265-7821 - Ext. 241

Home Address: 1225 Washington

Home Phone: 265-7362

Havre, Montana 59501

ALLEN LeMIEUX

County Attorney, Jefferson County

Office Phone: 225-3322

Home Address: 300 E. Centennial Avenue

Home Phone: 225-3359

Boulder, Montana 59632

SIMON LOOKING ELK

Resigned 12/3/74

Not replaced at this time

WILLIAM L. McCLAREN

Dean of Students

Flathead Valley Community College

Office Phone: 752-3411, Ext. 224

Home Address: Conrad Drive

Home Phone: 756-6360

Kalispell, Montana 59901

SHARI PETTIT
Registered Nurse
Home Address: 715 Power
Home Phone: 442-9841
Helena, Montana 59601

LARRY J. SCHROEDER
Architect
Office Phone: 248-6028
Home & Office Address: 204 Emerald Drive
Home Phone: 252-6145
Billings, Montana 59101
Member of Rimrock Guidance Foundation Advisory Board

PEGGY SKELTON
Elementary Teacher
Home Address: 2514 So. Hills Drive
Home Phone: 549-3147
Missoula, Montana 59801
Member of Crow Tribe

MONA L. SUMNER
Home Address: 2211 Oak
Home Phone: 259-7091
Billings, Montana 59101
Member of the Board of Rimrock Guidance Foundation

PATTI TYLER
Student, University of Montana, Missoula
Address: 1100 Long Staff, Apt. 3
Missoula, Montana 59801
Phone: 728-0809
Home Phone: 374-2378
Moore, Montana 59464

ROBERT L. VAN HORNE, Ph.D., Dean
School of Pharmacy
University of Montana
Office Phone: 248-4621
Home Address: 4 Martha's Court
Home Phone: 549-2152
Missoula, Montana 59801

LEGAL REFERENCES

REVISED CODES OF MONTANA
TITLE 69 - PUBLIC HEALTH & SAFETY
CHAPTER 62 - ALCOHOL AND DRUG DEPENDENCE

Section

- 69-6201. Purpose and intent of act--policy of state.
- 69-6203. Duties of department--department authorized to accept gifts--
enter into contracts--acquire and dispose of property.
- 69-6204. Receipt of financial assistance authorized--co-operation with
other agencies and organizations.
- 69-6206. State and local government to co-operate with the department--
not subject to its control.
- 69-6207. Deposit of funds from federal or private sources with state treasurer.
- 69-6211. Declaration of policy.
- 69-6212. Definitions.
- 69-6213. Powers of department.
- 69-6214. Duties of department.
- 69-6215. Comprehensive program for treatment.
- 69-6216. Facility standards--inspections--approvals.
- 69-6217. Acceptance for treatment--rules.
- 69-6218. Voluntary treatment of alcoholics.
- 69-6219. Treatment and services for intoxicated persons and persons
incapacitated by alcohol.
- 69-6220. Emergency commitment.
- 69-6221. Involuntary commitment of alcoholics.
- 69-6222. Records of alcoholics and intoxicated persons.
- 69-6223. Visitation and communication of patients.
- 69-6224. Application of Administrative Procedure Act.
- 69-6225. Departmental reports to legislature.

FEDERAL STATUTES:

- P.L. 91-616, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment,
and Rehabilitation Act of 1970.
Title III, (84 STAT. 1849)
Sec. 303 (84 STAT. 1850)
Sec. 311 (84 STAT. 1851)
- P.L. 93-282, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment,
and Rehabilitation Act Amendments of 1974.
Sec. 111 (88 STAT. 129)

OTHER:

Section

- 75-8905 Alcohol and drug dependency commission.

ALCOHOL SERVICES

CHAPTER 4

ALCOHOL SERVICES DIVISION

Sub-Chapter 1

State Plan, Standards

16-2.4(1)-S400 STATE PLAN (1) The plan is for state participation under P.L. 91-616 (Hughes Bill) and is necessary for application for a grant under this law. The department has been designated as the sole agency for supervision of the administration of the plan. The plan sets forth a survey of the need for the prevention and treatment of alcohol abuse and alcoholism, the facilities needed to provide services, and it serves as a guide for the development and distribution of facilities and programs throughout the state.

(2) The state plan of the Alcohol Services Division is adopted as a rule. The state plan is voluminous, and its inclusion in full in this rule would be cumbersome. It is deemed not expedient to include the entire context of the plan, and a summary of the plan is therefore given in section (1) of this rule. Copy of the plan is available for inspection, or copies thereof may be obtained at the expense of the person requesting the same at prices fixed to cover the cost of duplication and mailing. Inquiries should be made of the director of the department for inspection of the plan or requesting a copy of the plan. (History: Sec. 69-6203, R.C.M. 1947; NEW MAC Not. No. 16-2-41; Order MAC No. 16-2-17; Adp. 10/17/74; Eff. 12/5/74.)

Sub-Chapter 1

Alcohol and Dependent Drug Bureau

16-2.18(1)-S1800 STATE PLAN IS HEREBY REPEALED
(History: Sec. 69-6203, 82A-602, R.C.M. 1947; Order MAC No. 16-1; Adp. 12/31/72; Eff. 12/31/72; REP, MAC Not. No. 16-2-40; Order MAC No. 16-2-16; Adp. 10/17/74; Eff. 12/5/74.)

69-6213 and 69-6214, R.C.M. 1947, provide as follows:

"69-6213. Powers of department. The department may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(3) do other acts and things necessary or convenient to execute the authority expressly granted to it; and

(4) provide treatment facilities for alcoholics and intoxicated persons."

"69-6214. Duties of department. The department shall:

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the department of institutions and board of pardons in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the department of education, the superintendent of public instruction, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local government and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with the Department of Justice in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the governor an annual report covering the activities of the DEPARTMENT."

PREFACE

The 1975 State Plan for Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation is being submitted to insure continuity in planning and programming, to qualify the State of Montana for participation in the formula grant program authorized by P.L. 91-616 and P.L. 93-282, and to fulfill requirements of Section 69-6214, R.C.M. 1947.

The planning process utilized in the development of the 1975 State Plan involved the participation of many organizations, agencies and interested individuals. The actual writing and completion of the State Plan was done by staff of the Division. Those personnel with responsibilities in specific project activities were assigned appropriate sections of the Plan and provided necessary technical support by other Division personnel.

Input and planning assistance were provided by the following resources: Planning Subcommittee to the Montana Advisory Council on Alcohol and Drug Dependency, Regional Alcohol Plans, other state agencies, and local alcohol programs.

A planning subcommittee was appointed by the Montana Advisory Council on Alcohol and Drug Dependency to assist the Alcohol Services Division in the development of the 1975 State Plan. On November 7-8, 1974, this subcommittee met with division staff, local alcohol programs representatives, other community organizations and interested individuals. At the meeting, goals and objectives for the State Plan were discussed and it was decided that planning activity would concentrate on four areas: education, training, treatment and evaluation. Prior to the meeting, questionnaires were sent to all local alcoholism programs and Comprehensive Health Planning Regions. Information from the returned questionnaires was used extensively in the development of the State Plan.

Alcohol Services Division has provided a strong mechanism for regional planning over the past two years within Montana. Regional plans and updates have been submitted from the six catchment areas established by the 1974 State Plan. The regional plans were developed by local community action and compiled by professional health planners. They generally represent a consensus of opinion as to the extent of the problem, needs assessments and action plans to meet those needs. The recommendations and findings of the regional plans were utilized extensively in the development of this State Plan.

The ultimate goal or mission of the 1975 State Plan is to reduce the incidence of alcoholism and alcohol abuse. To reach this goal, a major effort must be generated and sustained at four major programmatic levels: prevention, training to occupational groups directly involved in providing alcohol services; the provision of a comprehensive continuum of care, and evaluation.

In Montana, as throughout the nation, there has been a measurable improvement in the accessibility and quality of alcoholism treatment services over the past years. However, only a small portion of alcoholics and persons affected by alcohol are receiving the services required. This situation seems, in part, to be due to the fact that many alcohol programs are capable of only responding to late-stage alcoholism and not to those people whose alcoholism can be identified at an early stage. Alcohol and Health, New Knowledge concludes that "major strides can be made in providing adequate treatment for alcoholism with proper and efficient utilization of resources and personnel." The 1975 Montana State Plan for Alcohol Abuse and Alcoholism has been designed as a guide to insure that local, regional and state resources are effectively mobilized to provide needed services to the citizens of Montana afflicted with alcoholism and alcohol abuse.

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INTRODUCTION

TRENDS IN ALCOHOL USE AND ABUSE IN MONTANA

Alcoholism and alcohol abuse are conditions that are found among all age and ethnic groups within Montana. However, a sense of urgency is being felt on a national, state and local level that these conditions are especially prevalent among special identifiable groups.

The following information provides indicators and trends of alcoholism and alcohol abuse among special high risk groups within Montana. State and local efforts can be more effectively directed, resources can be better utilized and a much greater impact can be realized in reducing the incidence of alcoholism and alcohol abuse in Montana, with these groups identified.

Apparent Consumption

Montana ranks among the states in apparent consumption age 15 and over as 24th in distilled spirits, 37th in wine and 5th in malt beverages. When compared to the U.S.A. average of apparent consumption in U.S. gallons per person in the drinking-age population (age 15 and over), as shown in Table I, Montana ranks close to the national average in distilled spirits, considerably lower in wine and much higher in the consumption of malt beverages.

Table I

APPARENT CONSUMPTION BY MONTANA AND U.S.A.
OF MAJOR BEVERAGE CLASS IN U.S. GALLONS PER PERSONS
15 YEARS OF AGE AND OLDER, 1972¹

	Distilled Spirits	Wine	Malt Beverages
Montana	2.52	1.14	34.95
U.S.A.	2.60	2.16	26.62

It also is significant to compare the apparent consumption of absolute alcohol in U.S. gallons per person age 15 and over for the U.S.A., the Mountain Region and Montana (1972). The apparent consumption for the U.S.A. is 2.63, the Mountain Region 2.92, and Montana 2.81.²

The percent rate of increase in the apparent per capita consumption of alcohol beverages in Montana from 1961 through 1972 has been approximately 11 percent. Figure I demonstrates this steady annual rise in apparent

¹Alcohol and Health, New Knowledge (1974), p.3

²The higher consumption rate of the Mountain Region is due to one state - Nevada - which has the second highest consumption rate in the country. Ibid., p.3-4

consumption of alcohol beverages over a twelve year period. In this time frame the increase in apparent consumption of malt beverages has been 8.4 percent, 15.2 percent for wine and 9.6 percent for distilled spirits.³ Table II demonstrates the annual increase in apparent consumption of alcohol beverages.

One indicator which demonstrates the increase in problem drinking rates and which compares with the apparent increase in consumption is the alcohol related misdemeanor arrests for Montana. Figure II demonstrates the steady annual increase in the number of arrests for Public Intoxicant and DWI. The increased rates for DWI was 30.2 percent for 1971-72 and 12.8 percent for 1972-73. The 12.8 percent increase between 1972 and 1973 can be considered to be most representative of anticipated future rate increases.

Risk Groups

In attempting to define risk groups within the total population, two basic sources of information were used to develop indicators: 1) arrest data supplied by the Crime Control Division, Montana State Department of Justice; and 2) the R.A.P. Scale test.

The following is a description of the R.A.P. Scale test and a series of matrixes which were extrapolated from the test and applied to the white population of Montana age 15 and over. The methodology seeks to identify persons with potential alcohol problems. It is assumed that persons from a group which can thus be categorized can be considered potential clients for alcoholism services.

The estimates are derived from a survey that has already been done, estimates of the degree of alcohol abuse risk in various age groups are taken, and finally aggregate figures that reflect age group dispersion of the state's population are arrived at.

The estimate of risk within the state's population was based upon an assessment of needs study conducted by the Rimrock Guidance Foundation, Yellowstone County, in 1972-73. The study utilized the R.A.P. Scale test which is designed to measure risk of addiction. A total of 3156 R.A.P. tests were administered, involving 5.2 percent of the "risk" white population (15 years of age and older) of Yellowstone County. It was directed toward both rural and urban segments of that county population.

Certain differences are apparent between the composition of the state's white population and that of Yellowstone County's white population. The most apparent differences are in density, urban vs. rural and types of employment. However, for purposes of establishing estimates of addiction risk, comparisons are made between various age groups from the state and Yellowstone County white population.

³ Percents are computed from indexes found in Table II.

Two aspects of the R.A.P. test must be qualified: 1) the test apparently does not utilize any mechanism to handle non-responses to the questionnaire; and 2) the questionnaire is soliciting attitudinal responses. It is understood that either item can, to a varying degree, affect the final results of such a study.

It was concluded by the study group that the age group 15-29 demonstrated a large numerical percentage of higher risk with the 15-19 age subgroup representing the largest percentage of high risk of all age grouping. The study concluded that without corrective action in the younger age grouping, Yellowstone County could be faced with an addictive rate of 8-9 percent of the general population within ten years.

The conclusions from the Yellowstone County study that an 8-9 percent addiction rate is quite possible, is close to the estimate of the Alcohol Services Division that the percentage of alcoholics among the white population is 8.5 percent.

The following matrixes are based upon the risk percentage from the Yellowstone County study and are applied to select statewide white population groups. The aggregate of these groups is to be considered the white risk population.

ESTIMATE OF ALCOHOL ADDICTION RISK
STATE OF MONTANA
1973

Matrix 1

White Risk Population

Age	Number
15-19	66620
20-24	48951
25-29	40266
30-34	35900
35-39	34736
40-44	37365
45+	200296

Matrix 2

Percent High Risk

Age	Percent
15-19	9.3
20-24	6.9
25-29	7.6
30-34	4.3
35-39	5.9
40-44	6.1
45+	4.5

X

=

Matrix 3

Estimate Number
High Risk

Age	Number
15-19	6196
20-24	3378
25-29	3060
30-34	1544
35-39	2049
40-44	2279
45+	9013

TOTAL 27519

Matrix 4

White Risk Population

Percent Medium Risk

Matrix 5
Estimate Number
Medium Risk

Age	Number
15-19	66620
20-24	48951
25-29	40266
30-34	35900
35-39	34736
40-44	37365
45+	200296

X

Age	Percent
15-19	23.5
20-24	15.6
25-29	13.7
30-34	11.7
35-39	11.4
40-44	10.8
45+	10.2

=

Age	Number
15-19	15656
20-24	7636
25-29	5516
30-34	4200
35-39	3960
40-44	4035
45+	20430

TOTAL 61433Matrix 6

White Risk Population

Percent Higher Risk
(High/Medium)Matrix 7
Estimate Number
Higher Risk

Age	Number
15-19	66620
20-24	48951
25-29	40266
30-34	35900
35-39	34736
40-44	37365
45+	200296

X

Age	Percent
15-19	32.8
20-24	22.5
25-29	21.3
30-34	16.0
35-39	17.3
40-44	16.9
45+	14.7

=

Age	Number
15-19	21851
20-24	11014
25-29	8577
30-34	5744
35-39	6009
40-44	6315
45+	29444

TOTAL 88954

Within limits, the use of alcohol related misdemeanor arrests data can be used to demonstrate risk groups with respect to age, race, and sex.⁴ Table III and Figure III demonstrates the large number of persons age 12 through 29 who are arrested for DWI and Public Intoxicant. Further, the age subgroup 20-29 which represents approximately 19.2 percent of the total risk population were responsible for 57.3 percent of the arrests in the two categories.

Table IV presents the number of arrests related to race and sex. While the Indian population represents approximately 3.9 percent of the total population,⁵ this group was responsible for 67.4 percent of Public Intoxicant arrests, and 26.6 percent of DWI arrests in 1973.

Table IV also demonstrates that alcohol related misdemeanor arrests predominately involve males. In 1973, only 13.4 percent of total arrests for Public Intoxicant and DWI involved females.

Conclusions

Age

In Montana, the apparent consumption of alcohol beverages is increasing at a predictable annual rate. This annual increase cannot be explained by the increases in those groups which annually "enter" the drinking population. Further, the consumption figures used in this report do not explain the consumption rates of age groups under 21 years of age. However, national surveys have concluded that a large portion of teenagers consume alcohol beverages. Among the young population, beer is the beverage of choice. These surveys also conclude that the quantity of alcohol consumed increases with school grade.⁶

The matrixes developed from the R.A.P. Scale test study show that the risk of addiction to alcohol or the development of problem drinking is extremely high for the 15 through 19 age group. It is concluded from the matrixes that while this age group represents approximately 14.4 percent of the total white "risk" population it scores extremely high in percent of high risk (22.5 percent), medium risk (25.5 percent) and combined high/medium risk (24.6 percent). The next highest scoring group developed from the matrixes is the 20 through 29 age group. This group representing 19.2 percent of the white risk population totaled 23.4 percent high risk, 21.4 percent medium risk and 22.0 percent combined high/medium risk.

The matrixes substantially agree with the conclusions found in Alcohol and Health, New Knowledge that the age group 18-20 has the largest portion of individuals that experience "some problem in connection with drinking (27%), followed by those aged 21 to 24 (18%)..."⁷ Earlier national studies, which had not included the age group 18-20, reported the 21-25 age group having the highest ratio of alcohol related problems.

⁴Methods of collecting arrest data and possible prejudices of arresting officers can to an extent influence the arrest figures used in this report.

⁵Division of Comprehensive Health Planning, SDH&ES (1973) County Profile, p.33

⁶Alcohol and Health, New Knowledge (1974), p.8

⁷Ibid, p.25

National studies indicate that males in their early 20's most frequently experience drinking problems.⁸ This observation generally is confirmed in Montana by using the indicator of alcohol related misdemeanor arrests in the age group 20-29. This group presents an extremely high ratio of arrests to population number (see Tables III and IV).

From studies conducted both on a national level and within Montana, and from available indicators it is apparent that the younger population (15-29) represents a special high risk group.

Indian

It has been well-established that ethnic background has a large bearing on drinking patterns,⁹ and subsequently on the incidence of alcoholism and alcohol abuse. However, it is very difficult to accurately determine the incidence of these conditions among the Indian population of Montana. This difficulty is due to the fact that the estimates of incidence varies from 10 percent to 50 percent of that population. It is assumed, however, that indicators are available which can be of value in determining the extent of the problem among this specific population.

For this report, two indicators are used to assist in determining the extent of alcoholism and alcohol abuse among the Indian population:

1) alcohol related misdemeanor arrests by offense and race; and 2) cause of death data.

Table IV demonstrates the disproportionately high rate of Indian arrests for Public Intoxicant and DWI as compared to the white population. While these figures may, to an extent, be inflated by external factors, they still appear to be significant.

The Bureau of Records and Statistics, State Department of Health and Environmental Sciences, maintains a continual surveillance of mortality data and provides an analysis of cause-of-death data. In a recent report (October 11, 1974) this Bureau reported a significant increase in cirrhosis of the liver in non-white females. The 1973 death rate for cirrhosis of the liver in non-white females was 99.0 as compared to the 1970-72 death rate of 46.2, which represents a statistically significant increase in the incidence of this disease. Numerous studies (Terris, 1967; Tokuhata, 1971) have demonstrated that a direct correlation exists between the levels of alcohol consumption and death rates from cirrhosis of the liver. The death rate for non-white females increased considerably in 1973 whereas the incidence of this condition among whites is down. The above information indicates that the apparent consumption of alcohol beverages for non-white females has increased significantly as well as the rates of alcoholism.¹⁰

⁸Ibid, p. 25

⁹Ibid, p. 7

¹⁰A test of significance utilizing the Chi-Square technique was used in this report. This category reported a Chi-square of 5.6427. Rates are based on death rates per 100,000 population.

Cirrhosis of the liver is a chronic degenerative disease which can be caused by liver infections and blood disorders, but is most usually associated with nutritional problems frequently contributed to chronic alcoholism.

TABLE II

INDEXES OF APPARENT PER CAPITA CONSUMPTION OF
ALCOHOLIC BEVERAGES (1961-72)
MONTANA
CONSUMING POPULATION (21 years of age and older)

Calendar Year	Beer Consuming Population		Wine Consuming Population		Distilled Spirit Consuming Population	
	Index Gallons 1961=100		Index Gallons 1961=100		Index Gallons 1961=100	
1961	32.9	100.0	.73	100.0	2.02	100.0
1962	34.0	104.3	.69	97.2	2.13	102.6
1963	34.9	105.7	.69	97.2	2.15	103.1
1964	35.0	108.5	.71	98.6	2.20	104.2
1965	36.3	110.5	.74	100.7	2.31	106.3
1966	36.9	111.4	.77	102.7	2.43	108.9
1967	38.6	113.8	.83	106.6	2.51	110.6
1968	37.3	111.9	.90	110.9	2.64	113.4
1969	38.7	113.9	.90	110.9	2.75	115.7
1970	42.4	119.1	1.03	118.3	2.83	117.3
1971	43.5	120.6	1.15	124.8	2.93	119.3
1972	42.0	118.4	1.37	135.6	3.02	121.1

The above table has been derived from per capita consumption based on the total alcohol beverage consuming population - instead of per capita consumption based on total population. This procedure was followed because the use of raw population data does not take into account shifts in the relative growth of the young population. In 1950, 37 percent of the total population in Montana was under 21 years of age; in 1960, 42.4 percent was under 21 years of age; and by 1970, that ratio had dropped to 41.7 percent.

The consumption indexes shown in this table represents the tax-paid quantities of alcohol beverages that enter consumer outlets. It does not show those that leave consumer outlets and thus such items as inventory overloads may distort apparent consumption in any given year.

TABLE III

MONTANA ALCOHOL RELATED MISDEMEANOR
ARRESTS BY OFFENSE & AGE¹
1973²

AGE	PUBLIC INTOXICANT	PERCENT OF AGE CATEGORY	DWI	PERCENT OF AGE CATEGORY	TOTAL OFFENSES	PERCENT OF AGE CATEGORY
1-11	6	.1	1	0.0	7	0.0
12-19	1455	14.4	307	8.9	1762	13.0
20-29	2462	24.4	1137	32.9	3599	26.5
30-39	1974	19.5	703	20.3	2677	19.7
40-49	1948	19.3	647	18.7	2595	19.1
50-59	1387	13.7	440	12.7	1827	13.5
60 & over	650	6.4	169	4.9	819	6.0
Unknown	<u>228</u>	<u>2.2</u>	<u>54</u>	<u>1.6</u>	<u>282</u>	<u>2.1</u>
TOTAL	10110	100.0	3458	100.0	13568	100.0

TABLE IV

MONTANA ALCOHOL RELATED MISDEMEANOR
ARRESTS BY OFFENSE, RACE & SEX
1973

OFFENSE	RACE			SEX	
	WHITE	INDIAN	OTHER	MALE	FEMALE
Public Intoxicant	3195	6814	101	8611	1499
DWI	<u>2506</u>	<u>920</u>	<u>32</u>	<u>3137</u>	<u>321</u>
TOTAL	5701	7734	133	11748	1820

¹Crime Control Division, Department of Justice, State of Montana

²In addition, many other arrests listed in records as disorderly conduct, disturbing the peace, vagrancy and others are commonly known to refer to public intoxication.

FIGURE I

INDEXES OF APPARENT PER CAPITA CONSUMPTION OF ALCOHOLIC BEVERAGES

1961 through 1972

CONSUMING POPULATION (21 years of age and older)

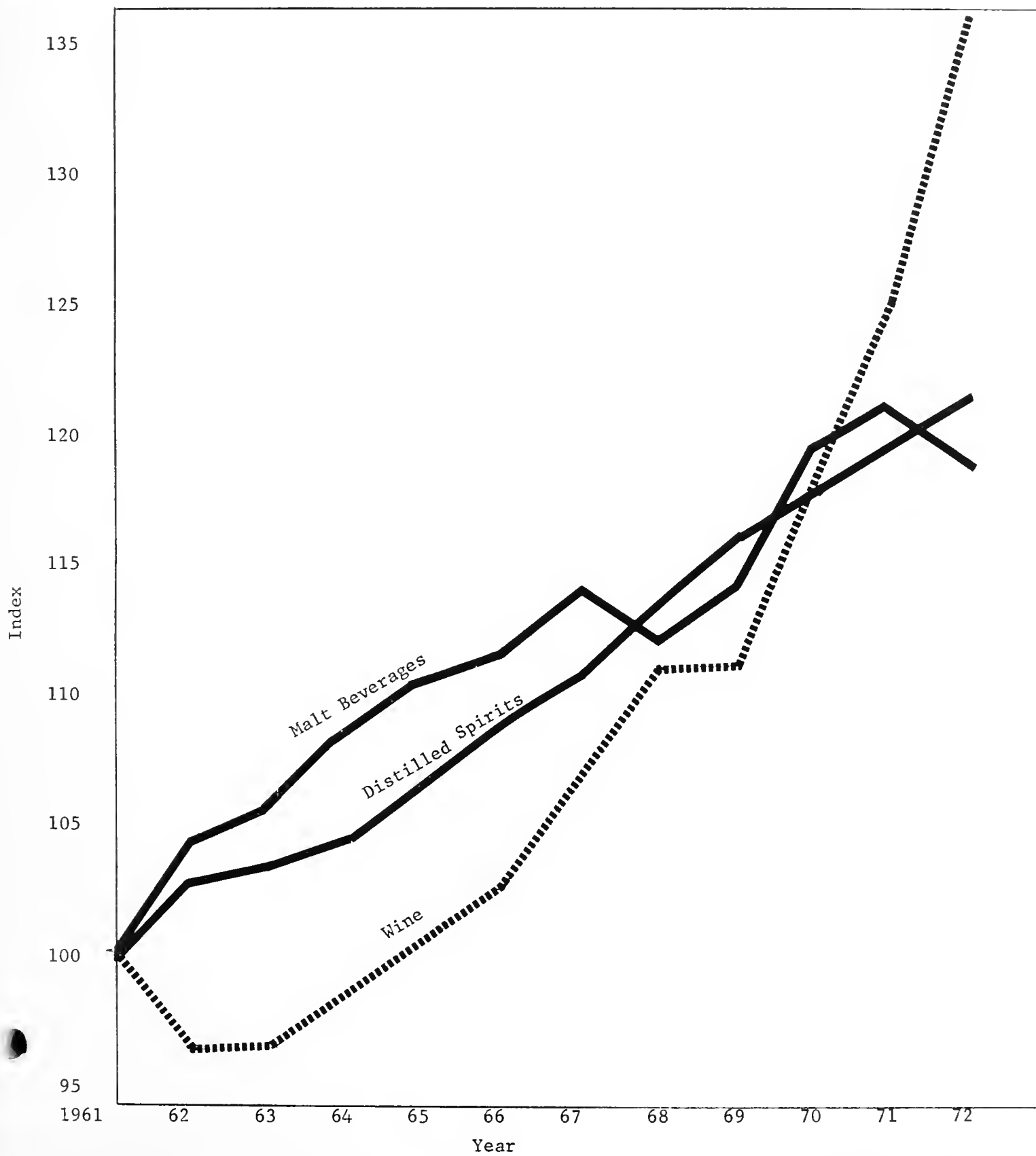


FIGURE II

MONTANA ALCOHOL RELATED MISDEMEANOR ARRESTS BY OFFENSE AND YEAR
1971-73

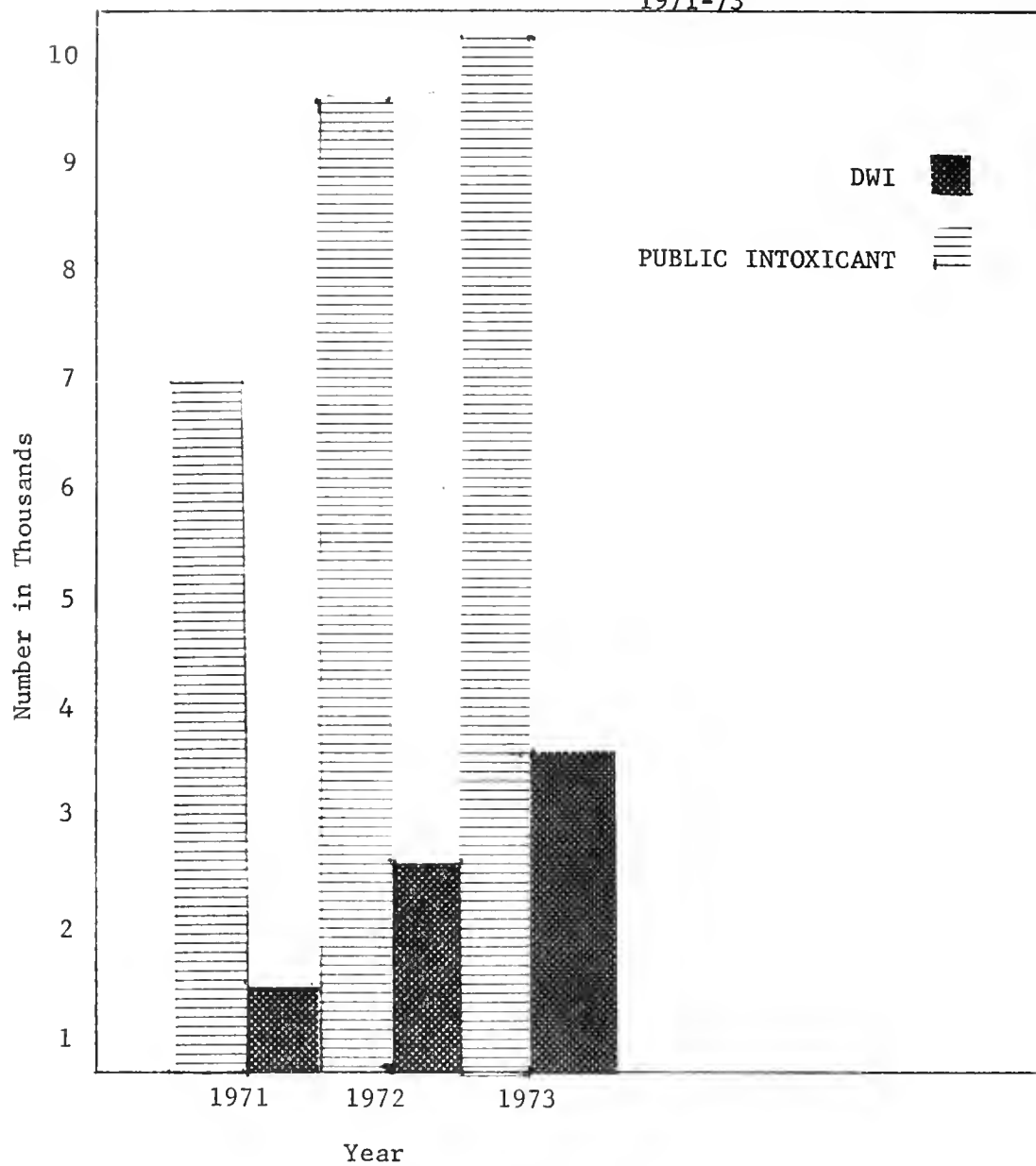
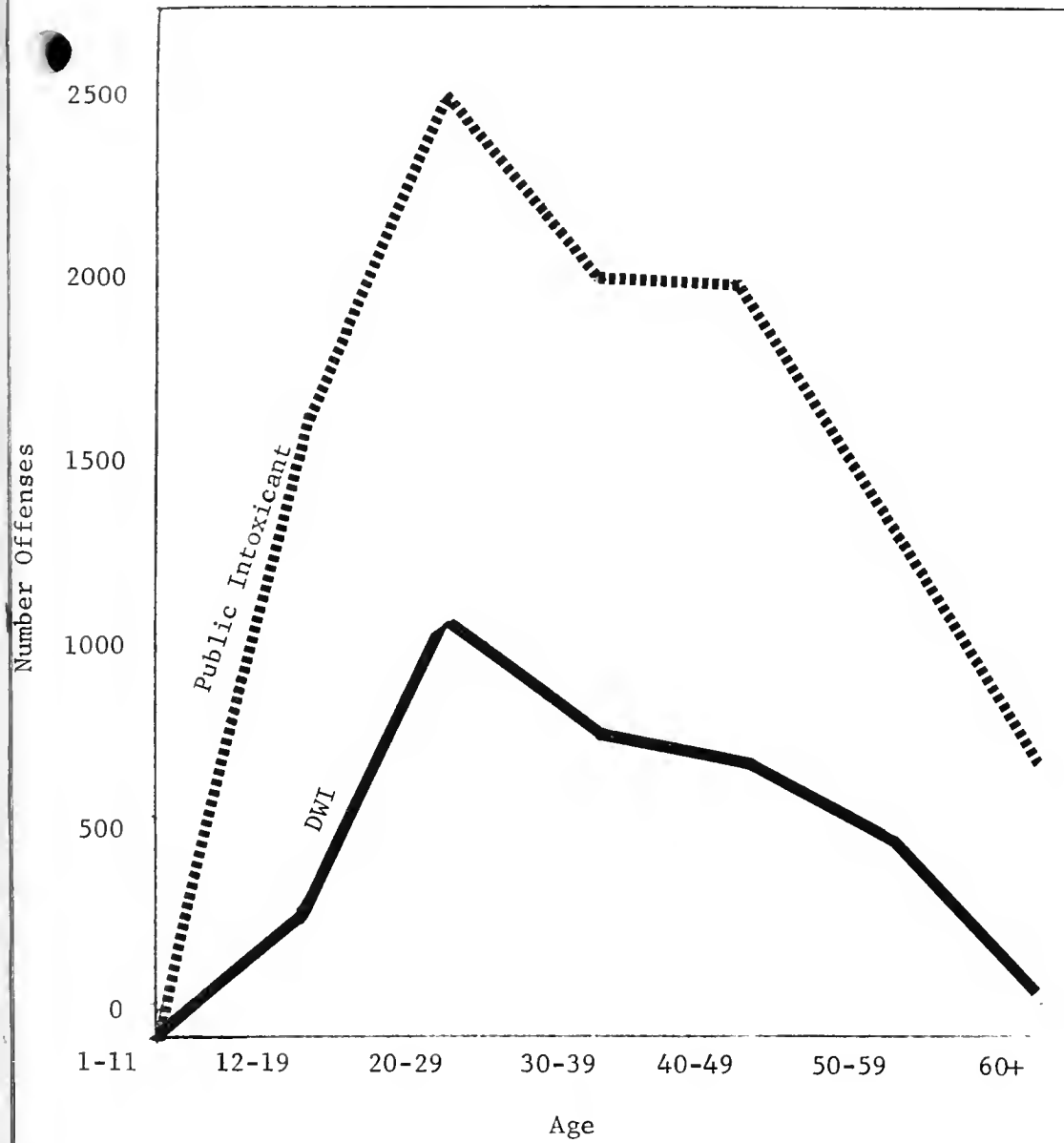


FIGURE III

MONTANA ALCOHOL RELATED MISDEMEANOR ARRESTS BY OFFENSE & AGE
1973



NEEDS ASSESSMENT

Available indicators identify the age group 15 through 29 as a special high risk group in Montana. For this age group, the indicators can be considered, to a great extent, to be manifestations of alcohol abuse and irresponsible attitudes toward drinking. There is a direct link between irresponsible attitudes toward drinking and the problem of alcoholism, therefore, a special emphasis must be directed toward this issue and age group.

The programmatic activity which would have the greatest long-term impact is prevention. Prevention activities must include not only the assisting of young people to adopt themselves realistically to a predominantly "drinking" society, but also to clarify and emphasize the distinctions between acceptable and unacceptable drinking, and to reduce the emotionalism associated with alcoholic beverages.

Another identifiable high risk group is the Indian population of Montana. While a great amount of funding and effort is being channeled into Indian alcohol programs, the impact of this expanded effort is difficult to assess. In the future, attention must be focused on the direction and management of these programs. Special consideration must be given to the unique and special needs of this high risk group.

The Alcohol Services Division, in the past, has initiated regional needs assessments and planning. This process involved the utilization of the Comprehensive Health Planning "B" agencies and Montana Indian Commission on Alcohol and Drug Abuse. The individual regional assessments have been compared and grouped in order to identify patterns and similarities that can be applied statewide.

The areawide alcoholism plans concluded that major new efforts are required in all aspects of prevention: to include formal on-going educational efforts in the school system, community education, public awareness campaigns, and a coordinate effort by those persons and agencies involved in prevention activities.

The regional needs assessments regarded the regionalization of alcohol program efforts as a major necessity. Equally important, is the need for the coordination of local resources. Action for Eastern Montana's Alcoholism Plan suggested that the coordination could be best achieved through the establishment of a Regional Alcoholism Coordinating Office. From a state programmatic viewpoint, such an approach to regionalization would be beneficial in that it would allow state agencies to better assist local alcohol programs in providing services to the general public.

A common theme from the regional plans was that the utilization of existing public services and community involvement/support are mandatory priorities. The plans regarded the expansion and upgrading of treatment facilities and program as a serious priority. The need for improved follow-up and outreach procedures also was expressed, as well as needs in the areas of in-service training and a useable data system. Special concern also was expressed for the needs of the urban Indian.

In Montana, the need exists for the development of comprehensive alcohol programs which can provide a full range of services to the general public. This range of services include: prevention, outpatient care, intermediate care, inpatient services and emergency care. The means to establish these comprehensive services exists through legislation passed in the 1974 Montana Legislative Session. The implementation of this law is vital to the development of adequate care for the alcoholic and alcohol abuser in Montana.

MISSION

The mission or over-all goal of this State Plan is to reduce the incidence of alcoholism and alcohol abuse in the State of Montana.

PREVENTION

GOAL

To develop prevention activities on a local, regional and statewide basis.

A. COMMUNITY ORGANIZATION

1. To develop three task forces in pilot project areas by July 1, 1975, which will coordinate and advise prevention activities within each project area.

By February 1, 1975, the size and location of each project area will be determined. Efforts will be made to place the project areas within two urban areas and a county school system. Next, a community resource within each area will be solicited to function as a lead agency for each task force. Wherever possible, alcohol programs will be used as the lead agencies.

By July 1, 1975, a series of organizational meetings will be conducted within each area in order to establish functional task forces. Alcohol Services Division staff will provide necessary coordination until the task forces are functional. It is intended that the membership of each task force will be comprised of broad representation within the project areas and will include alcohol programs, school authorities and school board members, other interested community services, organizations and interested persons. As it becomes feasible, new project areas will be established statewide. It is anticipated that each new project area will be represented by a task force which will coordinate and advise prevention activities.

B. ALCOHOL PREVENTION EDUCATION

1. To establish formal alcohol educational programs in the secondary school system within the three project areas by December 30, 1975.

The prevention staff of Alcohol Services Division will assist in establishing working relationships between school authorities and task forces in each of the project areas. This activity will be facilitated by including school authorities and school board members on each task force.

The curriculum for this educational effort will be based upon the Montana School Health Curriculum Guide produced by the State Department of Health and Environmental Sciences. It is anticipated that modifications will be made in this curriculum guide to meet the particular needs of each project area and this will be accomplished by working through the task forces, school authorities and appropriate state agencies such as the Health Education Bureau, State Department of Health and Environmental Sciences.

Before the curriculum is introduced into the school system, the prevention staff will conduct orientation sessions with those educators who will be using the curriculum.

2. To establish a value clarification curriculum which pertains to alcohol use in the elementary school system within the three project areas by December 30, 1975.

The Alcohol Services Division has agreed to participate in a consortium of state agencies which will purchase a value clarification film series entitled "Self Incorporated" which is designed for ages 11-13. This program is produced by National Instructional Television Center.

An appropriate teachers guide will be developed and incorporated with the film program and those portions of the film series pertaining to alcohol use will be presented to each task force.

Before the series are introduced into the school systems, the prevention staff will conduct orientation sessions with those educators who will be using the film series.

3. To assist the institutions of higher learning in establishing elementary and secondary alcohol education curriculum, by preparing and evaluating appropriate educational materials, and by participating in teacher seminars.

The above objective is open-ended and on-going. As educational materials become available, they will be prepared and evaluated.

It is anticipated that within the next year, the prevention staff will be involved in seminars and education courses conducted by the university system. This staff involvement will be primarily concerned with orientation of education major students with the value clarification film series.

4. To refine the alcohol curriculum that is included in the Montana School Health Curriculum Guide plan by June 1, 1975.

A series of inter-office and inter-department meetings will be held to determine what additions, deletions or changes should be made in the plan. Arrangements will then be made for appropriate changes in the plan in the form of addendum material.

5. To assist parents to be more effective in providing learning opportunities to youth on alcohol through assisting in the development of and implementation of community forums in the three project areas by December 1, 1975.

The prevention staff will assist in the development and/or acquiring of parent presentations and education materials which are appropriate for use by parents in alcohol education.

The prevention staff will assist the task forces in the development of the public forums. The active involvement in the forums by such organizations as the Parent-Teachers Association and the Junior League, American Federation of Women's Clubs will be solicited by the prevention staff.

6. To assist communities and special interest groups in providing for public awareness campaigns by assisting in the development of and providing technical assistance in community alcohol education programs.

The prevention staff, on request, will provide direct and technical assistance to local alcoholism programs and communities in the establishment of community alcohol education programs. The prevention staff also will perform promotional activities to interested local, regional and statewide organizations. This activity will be accomplished through workshops, seminars, radio and TV interview and talk shows, and public service spots.

For FY 1975, the prevention staff will work closely with the task forces in the three project areas in order that a broad based prevention program will be initiated.

C. PUBLIC INFORMATION

1. To create effective mass media techniques and provide for the proper dissemination of this alcohol information statewide by December 30, 1975.

A media consultant is assigned part-time to Alcohol Services Division and close working relationships have been developed between the consultant and the prevention staff.

In September, 1974, two sets of radio public service announcements (with three 30-second and three 60-second spots per set) were sent to 48 radio stations in Montana. A questionnaire was sent with the spots to each station. Questionnaires that have been returned indicate that there is a desire for more material and that station managers prefer to have such public service spots localized and produced specifically for Montana.

In February, 1975, two more sets of radio public service announcements (with three 30-second and three 60-second spots per set plus a drop-in sheet) will be sent to 48 radio stations in Montana. The effectiveness of the second series of spots will be evaluated by staff in May, 1975 to determine future development of general public spots.

By June 15, 1975, the prevention staff and media consultant will complete two sets of radio spots intended for youth. By August 1, 1975, these sets will be sent to a select number of radio stations which cater to the younger population. An evaluation component in the form of a questionnaire will be included.

By July 1, 1975, the project staff and media consultant will have developed a slide series for adoption to television. The process for completing this series will include determining an intended audience, development of a script, selection of music, production and dubbing.

2. To prepare, evaluate and disseminate informational materials on alcoholism and alcohol abuse to include: pamphlets, news articles and other literature on a regular basis.

As required, the project staff will prepare informational materials such as news articles to further prevention efforts statewide.

A method of pretesting informational materials such as pamphlets has been developed by the staff and will be utilized for all future literature prepared or received by the project. (see Appendix B).

As literature becomes available, it will be distributed principally to local alcohol programs, helping agencies and to the three task forces who, in turn, will distribute the material to the public. Tallies will be kept on this distribution and periodically checked to insure that materials are adequately distributed.

D. OUTREACH

1. To continue to administer the State Employee Assistance Program.

On February 11, 1974, Governor Thomas L. Judge released a policy statement for troubled state employees, assigning the Alcohol Services Division, State Department of Health and Environmental Sciences to administer an Employee Assistance Program for state employees and their dependents.

Initial contact has been made with all departments of state government and supervisor training sessions have been conducted in three of the departments.

The State Employee Assistance Program has provided direct service to seven state departments involving twelve employees. In addition, the program has provided direct service to two federal agencies involving troubled employees. A total of fourteen employees received assistance since the direct service component began in May 1974. Eleven of the fourteen employees (78%) have successfully responded to the program.

The Alcohol Services Division will continue to administer the State Employee Assistance Program in the coming fiscal year.

2. To assist in the further development of a community employee assistance program (MEAP).

A community employee assistance program has been established which is prepared to serve a population of approximately 10,000 employees and 30,000 employee dependents. The Occupational Consultants, Alcohol Services Division, have been actively involved in this program from its inception. Furthermore, the consultants were instrumental in the development of an NIAAA grant for the program. At present, the grant is in the final federal pre-funding activity. Should the grant be awarded, the consultants will provide the following services to that community project: arrange for the active participation of employees in the program; initially conduct supervisory training and instruct the program staff in the provision of this service; represent the state occupational program on its advisory board; and assist the program staff by providing in-service training and provide support in preparing evaluation reports.

3. To provide, on request, consulting services to employers statewide.

Initial contact has been made with the major employers statewide. Consultation and technical assistance is available to all employers or industries on request.

4. To maintain the support and endorsement of organized labor.

The Occupational Project has continually sought the support and endorsement of organized labor for the employee assistance programs that are being established. To date, the program has received letters of endorsement from the State Office, AFL-CIO, one Labor and Trades Council, a Teamsters local and an AFL-CIO District Council. In addition, the Labor and Trades Council is actively involved in the maintenance of a community employee assistance program.

At the AFL-CIO State Convention, the Occupational Consultants manned an information booth providing literature on both occupational programming and on alcoholism and alcohol abuse.

For the upcoming year, the consultants will maintain close contact with the labor movement and seek labor's assistance as it becomes necessary.

5. To maintain and update county profiles.

County profiles for Montana have been compiled showing the major industries, employers and resources. These profiles are updated on a quarterly basis.

6. To provide supervisor orientation for units of state government and to provide technical assistance in this area, to interested employers statewide.

Supervisor orientation is a process of presenting management skills which are required in the implementation of Employee Assistance Programs.

Supervisor orientation has been completed in three of the nineteen state departments and by July 1, 1975, all of the state departments will have received these training sessions.

7. To maintain the continuance of the Occupational Project beyond July 1, 1975.

The Occupational Project currently is in the last year of a three-year federal (NIAAA) grant, and on July 1, 1975 federal assistance to the project will cease. Section 69-6214, (12), R.C.M. 1947 declares that the State Department of Health and Environmental Sciences shall "assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state; ..." In order to assure the continuance of the Occupational Project, Alcohol Services Division, State Department of Health and Environmental Sciences will provide state monies to sustain this prevention activity. The state monies will maintain staff and support.

TRAINING

GOAL

To develop on a local, regional and statewide basis, training programs to meet the needs of professionals, and para-professionals in the field of alcoholism.

A. BOARD TRAINING

1. To increase the ability of boards of directors to function as a governing body by developing and administering board training sessions to three alcohol programs by December 31, 1975.

There has been no training for governing bodies in the majority of the alcohol programs by outside consultants. Some program directors have provided limited training to their boards in the area of internal program operation and alcohol education, but minimal training has been provided in the role and responsibilities of a board.

The Alcohol Services Division is developing a training program for governing bodies which will include lectures, group discussions, and work sessions on knowledge of alcohol and various kinds of treatment modalities, responsibilities, roles, and procedures of a governing body and responsibilities and roles of program staff. This program will be designed to fit the needs of each individual governing body in Montana. (see Appendix C, Board Training Outline).

B. STAFF TRAINING

1. To increase program effectiveness and the services provided to the alcoholic and his/her family by providing alcohol program staff with in-service training to be developed and offered by January 1976.
2. To develop and implement programs to provide in-service training to professional and para-professional staffs of helping agencies, on a regional basis by January 1976.

In the past, Alcohol Services Division has provided assistance in helping programs to obtain training for staff, but direct training by Alcohol Services Division has not been an on-going project. However, with the passage of H.B. 909, program staff training has become a major objective of Alcohol Services Division.

One staff member of Alcohol Services Division has been assigned as the state training coordinator. This individual has career and work experience in developing and implementing training design models. The coordinator will function as a team leader for other staff members involved in training.

The Alcohol Services Division will assess and determine the local alcohol programs needs and problems in order to develop, coordinate, and implement a training program to meet the in-service training needs of occupational groups dealing with the family of an alcohol abuser. This activity will be accomplished through an

inventory of all alcohol program staff as to background experience and education in order to determine minimum training standards. Alcohol Services Division also will discuss the program needs and problems with local governing bodies, executive directors, and staff in order to develop in-service training to meet the needs of each occupational group working with the alcohol abuser.

Alcohol Services Division will develop a training program for staff of alcohol programs and related helping agencies which will be designed to meet the needs of each program. The in-service curriculum will include, but not be limited to, lectures, group discussions, alcohol education, treatment modalities, confidentiality, accountability, administrative procedures and the staff's role and responsibilities to the governing board.

Alcohol Services Division, Montana Department of Health and Environmental Sciences will sponsor quarterly training sessions for Montana's alcoholism program directors, and will conduct specific training activities and disseminate information to the programs through FY 75.

The training sessions will be directed at key personnel of local programs and will include such items as the role and responsibilities of program directors, the role and responsibilities of program personnel; also to be included will be sessions on H.B. 909 rules, accreditation of programs and certification of counselors, and the function and techniques of prevention activities which will be implemented statewide. The statewide and national issues will be addressed, with applicable resource persons being utilized, dependent upon the topic of the meeting.

The Alcohol Services Division will provide travel expenses and per diem to each program director or his designated alternate when formally requested in accordance with departmental policies, so that representation from local programs can be assured at the quarterly training sessions.

The training session will be conducted over a two-day period and encompass up to eight hours. Remaining time may be used for travel and other meetings to be conducted in conjunction with the training experience.

C. MEDICAL PROFESSIONAL TRAINING

1. To establish a curriculum within a 24-hour training course for emergency medical services personnel currently being developed by Emergency Medical Services Bureau and the Montana Medical Education and Research Foundation.

Currently, the Emergency Medical Services Bureau, State Department of Health and Environmental Sciences and the Montana Medical Education and Research Foundation are developing a 24-hour training course for emergency medical services personnel. The course will be conducted in a number of sites by January 1, 1976 and will provide a structured curriculum to emergency medical service professionals. The Alcohol Services Division is working closely with the Emergency Medical Services Bureau in order that a portion of the training course will deal with the care of the acute alcoholic and intoxicated person, subject to approval by the Foundation.

A text, The Acute Alcoholic Patient, An Outline of Management in the General Hospital, has been printed by the Alcohol Services Division with permission of the author. This text will be distributed and utilized by the emergency medical personnel in any section of the curriculum dealing with the acutely intoxicated person.

D. TRAINING ASSISTANCE

1. To encourage alcohol program staff to participate in specialized training programs by providing travel expenses and per diem, tuition or registration fees, and/or various combinations of financial aid.

Training in the field of alcoholism has continued to be one of the priority areas for the expenditure of formula monies. Forty people received specialized training during FY 1974 in various aspects of alcoholism programming, program management and planning through the auspices of this Department. (see Appendix C, Procedures for applying for training monies).

2. To encourage interested people and/or organizations to develop and present seminars, training sessions, and/or workshops in the field of alcohol by providing technical assistance and expenses deemed necessary to carry out the mission.

Alcohol Services Division, Department of Health and Environmental Sciences, co-sponsored with the Montana Catholic Conference, a seminar for clergy, in three Montana cities, October 8-10, 1974. The seminar was presented to clergy by Father Joseph Martin, author of the film Chalk Talk, in Butte, Great Falls, and Billings. Attendance was sixty-seven (67), fifty-four (54), and forty-seven (47) respectively. Open meetings were held in Helena and Billings and had five hundred fifty (550) persons in attendance.

GOAL

To develop on a local, regional and statewide basis, a continuum of care for the medium and high alcohol addiction risk population.

A. UNIFORM ALCOHOLISM AND INTOXICATION ACT

1. To promulgate rules for the implementation of H.B. 909 "An Act Adopting Certain Provisions of the Uniform Alcoholism and Intoxication Act ..." by January 1, 1976.

Major portions of the Uniform Alcohol Intoxication and Treatment Act were passed by the Montana Legislative Session in 1974. (see Appendix D, H.B. 909). The intent of the legislation, as stated in the declaration of policy is as follows:

"It is the policy of the state of Montana to recognize alcoholism as an illness and that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society." The portions of the model act that were not passed are those sections that specifically decriminalize public intoxication. The bill was signed by Governor Thomas L. Judge on March 25, 1974. This law requires health and treatment standards for alcohol related treatment facilities and standards for acceptance of persons into treatment programs and facilities. The rule is authorized in Sections 69-6216, 69-6217, and 69-6218, R.C.M. 1947. A draft of the rule is attached and has been developed following considerable research into similar rules adopted by other states that have passed all or part of the Uniform Alcohol Intoxication and Treatment Act, specifically the rules from the States of Colorado, Rhode Island, Washington, Oregon, Kansas, and Connecticut were researched in this development. (see Appendix D, Draft of Rules). The research was carried out by the staff of the Alcohol Services Division with the assistance of the Legal Unit of the Department. A draft of the rule was presented to the Alcohol and Drug Dependency Advisory Council on August 20, 1974 and to a number of interested individuals throughout the state for additional input during preparation. There were a number of comments and suggestions that were incorporated into the rule.

Montana law requires implementation of rules, such as the ones being discussed, to be processed as outlined in the Montana Administrative Procedures Act. This Act requires public notice in the newspapers and an open public hearing, among other procedures.

The public hearing was held on October 17, 1974 with numerous people from throughout the state submitting formal testimony. Much of the testimony presented was against the adoption of this specific rule. Several of those who testified against the adoption of the rule felt the rule was not sufficiently specific.

John S. Anderson, M.D., Director of the Department of Health and Environmental Sciences was the hearing officer for this public hearing on the rule for implementation of the portions of the Uniform Alcohol Intoxication and Treatment Act. Dr. Anderson has established a task

force whose charge of responsibility is the revising of the rule. The task force consists of the following persons who were appointed on December 17, 1974:

<u>Name & Address</u>	<u>Representing</u>
Mr. Ed Mahn, Director N.W. Montana Areawide Health Planning Council 127 E. Main, Box 516 Missoula, Montana 59801	Comprehensive Health Planning "B" Agency
Gordon Gerrish, Ph.D. Box 434, Drawer E Ronan, Montana 59864	Board Chairman, local program
Acting Director MICADA Cisel Hall - EMC Box 570 Billings, Montana 59101	Montana Indian Commission on Alcohol and Drug Abuse
Mrs. Mona Sumner 2211 Oak Billings, Montana 59102	Alcohol & Drug Dependency Advisory Council Member
H. Brian Des Roches Deaconess Hospital 2813 9th Avenue N. Billings, Montana 59101	Director of Administration Services, Billings Deaconess Hospital
Mr. Danny Peressini Hill-Top Recovery Center 1020 Assiniboine Havre, Montana 59501	Director, Hill-Top Recovery
Mr. Jack Charlson Executive Director Community Health Services for Alcoholism 603 W. Porphyry Butte, Montana 59701	Alcoholism Programs of Montana, Inc.

The task force will meet as often as necessary and return the completed rule as soon as possible but not later than July 1, 1975. When the revised rule is returned to Dr. Anderson, it will be re-entered into the Administrative Procedures process. A public hearing may again be scheduled and input from the public solicited. At such time as the rule becomes acceptable to the hearing officer, the rule will become effective approximately forty days later. The rule must be effective and the law fully implemented by January 1, 1976. (Sec.69-6224, R.C.M. 1947).

2. To work toward the passage of legislation in the 1975 Montana State Legislative Session which will provide for total decriminalization of the alcoholic and/or intoxicated person as provided for in the Uniform Alcoholism and Intoxication Act.

Legislation is to be introduced in the 1975 Montana State Legislative Session to provide for total decriminalization of the alcoholic and intoxicated person. Alcohol Services Division staff will serve as resource persons as requested by state legislators.

3. To insure that a referral mechanism is operative, statewide, which will provide the intoxicated person with detoxification services by January 1, 1976.

Alcohol Services Division currently is working closely with the Emergency Medical Services Bureau, Department of Health and Environmental Sciences, in providing alcohol resource lists to emergency medical personnel throughout the state.

Alcohol Services Division will provide technical assistance and coordination to local alcoholism programs and hospital facilities so that affiliate agreements will be made and maintained between these community services.

Staff from the Alcohol Services Division will promote and, where necessary, conduct public forums, workshops and seminars for law enforcement personnel, and other service agencies and individuals to insure that the intoxicated person receives proper detoxification and other emergency care as deemed necessary. Where possible, this activity will be done in cooperation with local alcohol programs. The conducting of seminars will include presentations at the Law Enforcement Academy at Montana State University.

4. To approve alcohol treatment facilities which meet the requirements of rules for implementing Sections 69-6216, 69-6217 and 69-6218, R.C.M. 1947.

As the rules are promulgated, the Alcohol Services Division will solicit requests from alcohol programs for approval as acceptable treatment facilities. (see Appendix D, Definition of Treatment Components). The requests for approval will be required to be in writing and must present documentation of the facilities' compliance with the rule. A site visit by Division staff will be arranged for each applicant seeking approval. As the applicants are approved as acceptable alcoholism treatment facilities, they will become eligible for funding (see section on Allocation of State General Funds).

Alcohol Services Division will compile annually a list of approved treatment facilities for distribution statewide.

5. To assist alcohol programs, which do not meet the minimum standards set forth in the rule, to upgrade and/or develop appropriate service components so that they will comply with the rule.

The Division staff will provide technical assistance and consultation to alcohol programs by assessing the needs of programs and assisting in the development of services which are presently lacking or non-effective.

6. To encourage and foster the development of alcohol services in those areas where no resources are presently available.

The Alcohol Services Division will be principally concerned in generating support and interest among community and target populations in these areas to include law enforcement, government officials, and medical personnel. The Division staff will foster the development of task forces or committees within these areas. These committees can provide the basis for the development of alcohol programs which will meet the needs of a service area.

It is anticipated that the regional representatives will concentrate their efforts in areas where no services are currently available in order to assist in the development of adequate services for the alcoholic and alcohol abuser.

7. On July 1, 1974, the Alcohol Treatment and Rehabilitation Program was transferred from the Montana State Hospital at Warm Springs to the Galen State Hospital. At this time the definition of alcoholism was changed from a "mental illness" to that of an "illness", as noted in Section 80-1705, R.C.M. 1947. This is in keeping with Section 69-6211, R.C.M. 1947. From July 1974 to December 31, 1974, four hundred and eighty-four (484) persons have been admitted to Galen for alcoholism.

B. FOLLOW-UP

1. To insure a continuum of care by referral of individuals discharged from alcoholism treatment facilities to approved local alcoholism programs and/or Alcohol Services Division, Department of Health and Environmental Sciences.

Procedures will be established whereby treatment facilities will submit to Alcohol Services Division, Department of Health and Environmental Sciences, on a weekly basis, a list of those patients discharged. At the time of discharge, treatment facilities will refer clients to approved alcohol programs and if no approved program is located within the community, a referral will be made to Alcohol Services Division, Department of Health and Environmental Sciences to insure follow-up services.

Regional representatives will cooperate, coordinate, and provide technical assistance to local alcohol programs to insure the delivery of follow-up services. Alcohol Services Division will negotiate and develop methods to insure follow-up services for those individuals returning to Montana from out-of-state treatment facilities.

Alcohol Services Division will monitor and measure the effectiveness of follow-up services through a monthly report summarizing admissions, dismissals and referrals provided by approved local alcohol programs and alcohol treatment facilities.

Approved facilities will provide any additional information to Alcohol Services Division when deemed necessary to evaluate continuum of care.

2. To provide technical assistance to alcohol programs so that an effective followup system will be developed and implemented statewide.

Follow-up will be designed to provide care to patients who have progressed sufficiently through emergency inpatient, intermediate and/or outpatient services to a point in their recovery where they would benefit from a level of continued contact which will support and increase the gains made to date in the treatment process.

C. REGIONAL PROJECT

General

In the past, the amount of service that could be provided to communities and local alcohol programs by the Alcohol Services Division has been limited by constraints of staff time and distance. In addition, H.B. 909, which was signed by Governor Thomas L. Judge, March 25, 1974, placed new responsibilities on the State Department of Health and Environmental Sciences. This legislation directs the Department to "develop, encourage and foster statewide, regional and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons..., and provide technical assistance and consultation services for these purposes." H. B. 909 further instructs the Department to "establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons" and "provide for adequate and appropriate treatment for alcoholics and intoxicated persons."

In order to accomplish the above, the staff of Alcohol Services Division must be expanded. To best utilize an expanded staff, it is proposed that a regional representative be located in each Comprehensive Health Planning region and the Indian cultural region of the state. The representatives would facilitate the maintenance of communication between local programs and the state office. Most importantly, the representatives would assist the state in fulfilling the obligations and responsibilities as dictated by law.

Goal

The goal of this project is to establish reliable continuous interaction between Alcohol Services Division and local alcohol programs and to assist in supplying the services necessary to reduce the incidence of alcoholism and alcohol abuse.

Objectives

1. To implement a system of follow-up which will insure a continuum of care for the alcoholic either re-entering society or seeking assistance from a proper treatment facility, and to provide outreach services for the State Employee Assistance Program.
2. To assist the Alcohol Services Division in establishing a system of care which is accessible in each region. The system would include the services of inpatient care, emergency services, outpatient services, intermediate care and prevention.

3. To assist and be involved in developing primary prevention activities on a community and regional basis through a positive alcohol education program.
4. To implement an appropriate system to evaluate all components of the alcohol services care system.
5. To determine the needs for training and to assist in the development and implementation of training programs designed to meet the needs of professional and paraprofessional staff on a programmatic regional and statewide basis.

In addition to their primary roles as listed in the above objectives, the field staff will periodically survey all existing facilities and update surveys and other information to be included in the State Plan.

Methods

The staff of the Regional Services Section will consist of six regional representatives each assigned to a Comprehensive Health Planning region and Indian cultural region within Montana. The regional representatives will be responsible for assigned activities in their respective districts.

Supervision of the regional representatives will be provided by existing Division staff on an assigned basis. Division staff will be assigned the responsibilities for the coordination and supervision of all activities of specified regional representatives on a rotating basis. The assigned Division staff will be directly responsible to the Administrator, Alcohol Services Division. Other Division staff will coordinate their activities with the regional representatives through the assigned staff.

The supervision of the regional representatives will be composed of two phases incorporating a transition from one of training and very strict supervision to that of being assigned specific tasks subject to periodic review.

During the first phase (six months) of employment, the representatives will undergo intensive training both in-house and through assignment to established training programs. (see Appendix D, Outline Regional Staff Orientation). In the first phase, the representatives would perform field work under the direct supervision of assigned Division staff coordinators. At the end of this period or at the discretion of the Administrator, Alcohol Services Division, the representatives would begin the second phase of their employment.

Upon assignment to the second phase, the representatives will perform assigned activities in their respective districts as directed by the assigned Division staff coordinators.

Evaluation

The Regional Services Section will be evaluated through the following indicators:

1. Number of follow-up and referral contacts initiated and completed per month.
2. Record program activities and people reached in each function area.

3. Conduct evaluative measures for programs in assigned regions (i.e., pre-post test).
4. Number of requests received for services.
5. Monthly narratives on progress in achieving stated objectives for each function area.

Project Personnel

1. Staff Coordinators. Will be provided by existing Alcohol Services Division staff on an assigned rotating basis. Responsible for organizing, promoting and coordinating the Regional Section, Alcohol Services Division. Maintains liaison with other Division staff, other state and local government agencies, as well as local alcohol programs, Mental Health Centers, other community services and civic organizations. Will be responsible for directing the field staff in community organization, alcohol programming, prevention activities, follow-up and outreach, and evaluation. The staff coordinators will be directly responsible to the Administrator, Alcohol Services Division.
2. Regional Representatives. Will maintain contact with local alcohol programs and treatment facilities, local health departments, medical societies, Mental Health Centers, other organizations and volunteer groups, informing them of matters concerning Alcohol Services Division programs and will be available to attend meetings and other public gatherings to provide information. Will serve as resource speakers for school and community meetings. Will maintain records for the activity in their regions and will submit monthly reports and any other reports necessary to the state office. Will coordinate overall state alcohol programming in their regions. Will become involved in and assist with any program development which will be beneficial and necessary to the successful continuation of alcohol programs and will become involved in and assist with program evaluation. Will serve as a liaison in their regions and be responsible for accepting referrals from treatment facilities and insuring continuum of care for the referral, and will insure that appropriate referrals are made to proper treatment facilities as needed. Will attend training sessions and seminars to further their competence in alcohol programming. The Indian representative will be of American Indian ethnic origin and will be assigned as staff liaison for Indian alcohol programs and Montana Indian Commission on Alcohol and Drug Abuse.
3. Clerk Typist III. Under the general supervision of Divisional Secretary and the Administrator, Alcohol Services Division, will perform typing and clerical work. Will maintain a central follow-up register and under the supervision of assigned Division staff will receive and relay referral and follow-up information to field staff. Will provide a limited amount of clerical support to the regional representatives.

Division Support

The Alcohol Services Division will provide support for the field staff utilizing existing and new duplication, transcription and dictating equipment.

The Clerk-Typist III will provide clerical duties to the field staff as directed by the Divisional Secretary.

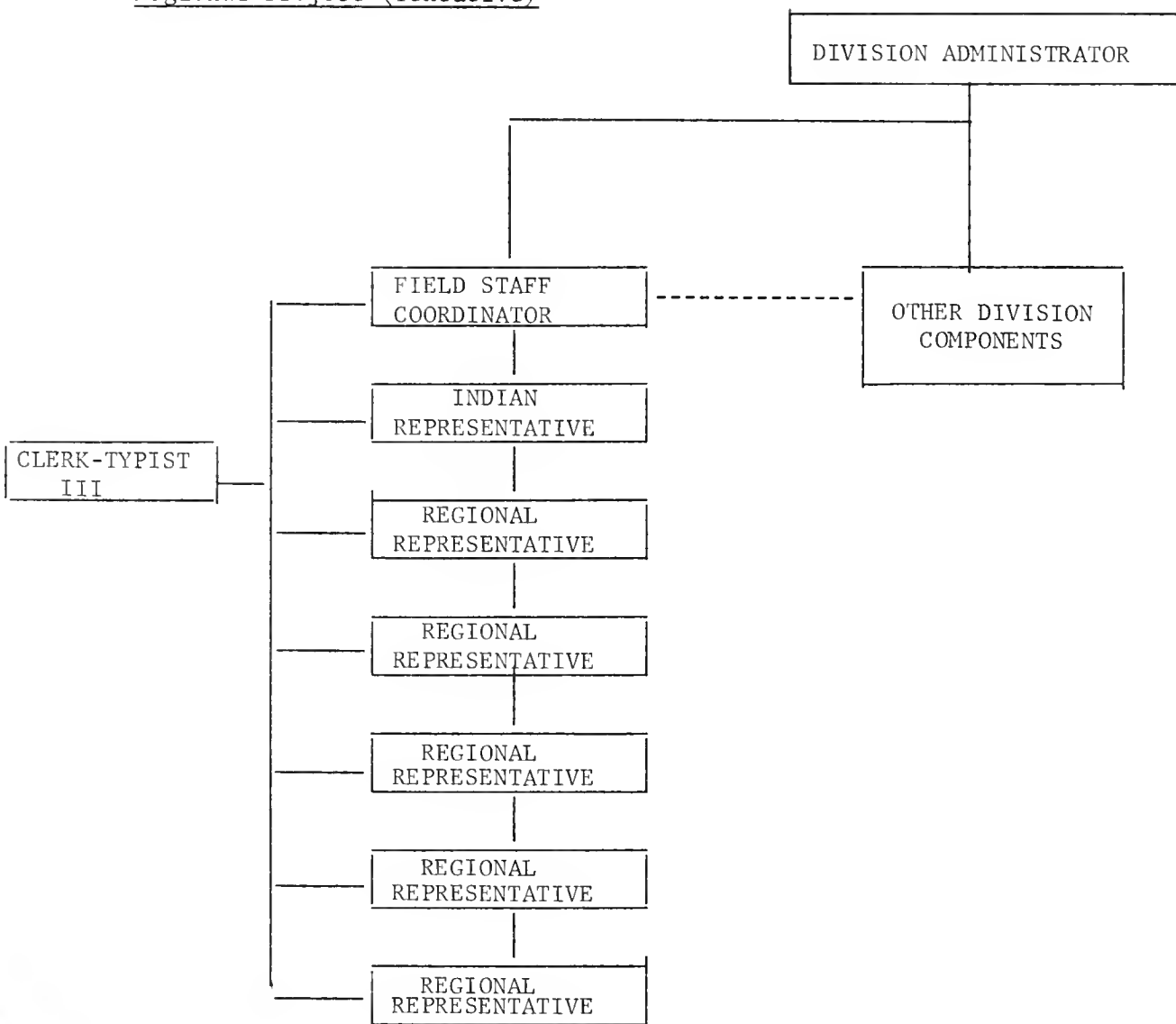
Field Staff Locations

Field staff locations have not been developed at this time but will be assigned as the regional representatives are employed. Wherever possible, the representatives will be housed within an existing community service such as a local health department, Mental Health Center or local alcoholism program. Agreements will be made with these community services for needed clerical and other support for the regional representatives.

Funding

Funding for the project will come from State General Fund monies appropriated to the Department.

Regional Project (Tentative)



GOAL

To develop and implement procedures which will effectively measure each component of state, regional and local programs.

A. PROGRAM EVALUATION

1. To provide for proper evaluation which will encompass the measuring of progress toward achieving the stated objectives of the State Plan and by measuring the progress of local alcoholism programs toward achieving their stated objectives.

This evaluation procedure will be accomplished through measuring program efforts and effects by a quarterly review of progress toward achieving stated objectives. The quarterly review will include an examination of activity reports, records of daily activity, monthly narratives, time lines, data collection from local programs and pre-post test significant.

For prevention and training activities pre-post test significant procedures will be used extensively. Evaluation of knowledge and attitude changes will consist of documentation and anecdotal records on the assessment of pre-training functioning versus post-training functioning of target groups.

2. To initiate and implement the evaluation of the programmatic activities of the Alcohol Services Division and the advisory functions of the Montana Alcohol and Drug Dependency Advisory Council before the end of FY 1975.

The Alcohol Services Division currently is negotiating with three consultant firms in order to establish a contract for evaluative purposes. This firm will be contracted to provide evaluation of Alcohol Services Division programmatic activities. Also it is anticipated that the consultant firm will evaluate the role, functions and interrelationships of Alcohol Services Division to the Montana Advisory Council on Alcohol and Drug Dependency, local alcoholism programs, and other community services involved in alcohol program activities.

B. MANAGEMENT INFORMATION SYSTEM

1. To develop, pre-test, and implement a simplified data collection form and analysis system by March 1, 1975, which will provide meaningful information to measure program effectiveness to both local programs and Alcohol Services Division, Department of Health and Environmental Sciences.

A simplified data collection and analysis format has been developed by Alcohol Services Division, Department of Health and Environmental Sciences. This data collection form is currently being pre-tested by four local alcohol programs, each functioning at a different stage of development.

This method of data collection and analysis, once fully operative, will provide Alcohol Services Division with the necessary information to develop a substantive, well-documented data base and state profile.

A data collection and analysis system relating to those needing services and those obtaining such services was implemented in FY 74. The response was poor as the format was complicated, and the alcohol programs had limited staff which necessitated the same people who were rendering services to collect data.

It is anticipated that the rate of response will increase with the implementation of a simplified data collection form to develop a substantive, well-documented data base. Program activities will be monitored through this standardized reporting system.

If this data collection and analysis system does not prove to be adequate, the Alcohol Services Division will consider employing a professional management firm to develop and implement an adequate management information system for Montana.

C. INCIDENCE AND PREVALENCE STUDY

1. To participate in an incidence and prevalence study on the use of alcohol and other drugs.

In 1974, the Alcohol Services Division contributed financially (\$5000) to an Incidence and Prevalence Study being conducted by the Addictive Disease Unit. The study consists of an attitudinal survey with 500 respondents statewide. When completed, information from the study will be compared with other existing data and if pertinent will be utilized by the Division.

ALLOCATION AND UTILIZATION - P.L. 91-616
FORMULA FUNDS 1974 - 1975

As authorized by P.L. 91-616 and P.L. 93-282, upon submission and successful review of an annual State Plan, the State of Montana is eligible for \$200,000 per year in formula funds from the National Institute on Alcohol Abuse and Alcoholism.

The allocation of FY 1974 P.L. 91-616 formula funds was essentially as it was in the FY 1973 Plan. The funds were allocated on a regional basis to the four Comprehensive Health Planning Councils, Action for Eastern Montana and the Montana Indian Commission on Alcohol and Drug Abuse. The amount of funds available to each of these six planning areas for FY 1974 was increased from the \$27,000 level of FY 1973 to \$28,500. Contracts with local programs were encouraged, if the regional planning group so prioritized the utilization of the formula monies. Allocation of these formula funds to programs were recommended by Comprehensive Health Planning "B" agencies. These funds were made available to the six planning areas as soon as they were received by the Department of Health and Environmental Sciences.

The total dollar amount of funds available to the six planning areas from the formula grant was \$171,000. The formula grant of \$200,000 was utilized in the following manner:

\$171,000	(85.5%)	Allocation to planning areas
20,000	(10.0%)	Administration
6,000	(3.0%)	Training
<u>3,000</u>	<u>(1.5%)</u>	<u>Evaluation</u>
\$200,000		

Three years have passed since the inception of the formula funding program by NIAAA. In these three years, the allocation and utilization of the formula funds have been primarily intended for developmental purposes. These funds have been used to assist local alcohol programs, communities and regions to develop and implement adequate alcohol services for the citizens of Montana.

In 1975, it is the intent of Alcohol Services Division to use portions of the formula funding for evaluative purposes. After three years of development, it is time to measure the impact and re-evaluate the direction of past programming. Alcohol Services Division will soon undergo intensive evaluation by a consultant firm in order to measure service effect and management capabilities. However, for evaluation of alcohol programming throughout the state to be effective, not only the state office, but all alcohol programs and allied agencies must be evaluated.

The FY 1975 Public Law 91-616 formula funds will be allocated for evaluative purposes on a regional basis to the six planning regions currently being utilized in this State Plan. The amount of funds that will be available to each region in FY 1975 is \$20,000. The funds will be used to evaluate local alcohol programs' service effect, management capabilities, data gathering and analysis, and follow-up procedures. The evaluation process will necessitate program and fiscal audits, and assessment of management services.

The evaluation will be done by professional consultant firms. The Alcohol Services Division will contract directly with reputable firms who will perform evaluation services to alcohol programs within each region. The contracted firms will present packaged evaluation proposals to individual program Boards of Directors and to the Alcohol Services Division for approval.

\$20,000 of the formula funds will be utilized for assessing the role, function and impact of other state agencies who are involved in alcohol programming, such as Galen State Hospital of the Department of Institutions, Social and Rehabilitation Services, and others.

Ten percent (\$20,000) of the formula grant allotment is being requested to pay for administration of the State Plan. Costs to be covered by this amount of money include:

1. Materials and services such as printing, xerox, and photocopying, rent, telephone, expendable and desktop supplies, minor office equipment.
2. Staff travel in development and administration of State Plan.
3. Expenses of Alcoholism Advisory Council, per diem and travel at rates not to exceed those authorized by state statute.
4. Agency membership in alcoholism organizations.
5. Other administrative costs necessary to develop and administer the State Plan.

Training of professional, para-professional and developing personnel is a high priority in the Montana State Plan and a portion of the formula monies (\$20,000) is being allocated for this purpose.

Short term training in recognized programs such as Utah Summer School of Alcohol Studies, the International School of Alcohol Studies in North Dakota, and seminars and training institutes of similar nature will be given consideration for funding. Travel and per diem expenses at prevailing state rates will be paid, as well as registration fees for successful applicants. Applicants for such reimbursement must show acceptance by the particular training program in their application to this Department, and must show that the training is relevant and applicable to their particular work situation, and must submit a short narrative summary report following the training experience.

Applicants should consider contacting the Division as early as possible in the application procedure to the specific training program to assure that there is a possibility of funding being made available through the Division. The Division itself will conduct training as necessary and has made arrangements with specific training programs and will provide scholarships in the form of per diem and travel expenses to such training. Such training may be either clinical or of a specialized nature. The Division will not pay the salaries of the personnel from local programs during the training.

The Division is establishing a seminar schedule for alcohol program directors which will be held on a quarterly basis in Helena. In-service training for alcohol program board members and staff also is being scheduled by the Division. Necessary formula monies will be allocated for these activities.

A portion of the formula monies (\$20,000) will be held in a discretionary fund. These funds will be used primarily for planning assistance to alcohol programs within Montana. The planning assistance will include the purchasing of services from private planning consultants and from the Comprehensive Health Planning Agencies.

This pattern of allocation is for the total amount of money available to the State of Montana under the formula grant of Public Law 91-616 for Fiscal Year 1975, \$200,000.

The FY 1975 formula grant of \$200,000 will be utilized in the following manner:

\$120,000	(60%)	Allocation by planning regions
20,000	(10%)	Administration
20,000	(10%)	Training
20,000	(10%)	Discretionary
<u>20,000</u>	(10%)	Evaluation - state agencies
\$200,000	(100%)	Total

POLICIES FOR THE
ALLOCATION OF ALCOHOLISM FUNDS FROM THE STATE GENERAL FUND

1. Requests for the alcoholism program funds should be in writing and directed to the Alcohol Services Division, Department of Health and Environmental Sciences on the forms and in a format prescribed by the Department.
2. These funds may provide for all expenditures for (Section 3, H.B. 748, 1974 Legislative Session, signed 3-28-74):
 - a) personal services
 - b) all other ordinary and necessary expenditures for the operation of the agency and the program to which the appropriation applies.
 - c) repairs and maintenance other than major alterations of existing buildings.
 - d) the purchase or replacement of capital items other than expenditures for the construction, improvement or furnishing of buildings or purchases of buildings or land unless specifically authorized.
3. The local agency requesting these funds must provide one-third cash match before any funds can be authorized. (See above citation).
 - a) in kind or soft match will not be acceptable.
 - b) none of the funds being offered as match may have been previously used as match and must be available for expenditure during the same fiscal year as the requested state funds.
 - * c) the Department will require a written statement signed by a certified public accountant indicating that the match is available and meets the above conditions.
4. The local agency requesting these funds must provide documented assurance that fiscal records of the expenditures from these funds will be maintained for five years after the fiscal year of funding and be available for review at the request of the Department.
5. The expenditure of these funds must be recorded distinctly from all other funds so as to maintain a clear audit trail.
 - a) co-mingling of these funds with other funds is not acceptable.
6. The local agency requesting these funds must submit a detailed budget and narrative describing how the funds will be used. Such budget should reflect all funding sources utilized by the local agency.
7. The local agency requesting these funds must describe the internal procedure for changing, modifying or amending this budget.
8. Requested funds of up to \$1000 will be arranged on a contract to be approved by the Alcohol Services Division.
9. Requested funds of more than \$1000 will be arranged on a contract to be approved by the director of the Department of Health and Environmental Sciences.
10. A program must submit written consent signed by the chairman of the board indicating that the program may be audited by the legislative auditor (79-2310, R.C.M. 1947).

- * a) the program must provide a certified audit completed within the previous 12 months with application for approval.
- * 11. A local program must show that it has at least \$300,000 liability insurance on its buildings, its premises and any vehicles used for the transportation of clients, including staff-owned vehicles.
- * 12. A program must submit proof of Internal Revenue Service tax exempt status or application for such status.
- 13. These state funds may not be used for fines, penalties, interest, loans, gratuities, and may not be used to repay bad debts or prior financial obligations.
- 14. These funds may not be used to purchase motor vehicles.
- 15. Capital goods with a new purchase price of \$100. or more purchased with these funds will become the property of the Department of Health and Environmental Sciences. Should a program terminate, these capital goods will be the property of the Department of Health and Environmental Sciences for disposition.
- 16. The amount of money that may be reimbursed for travel and per diem costs may not exceed the specified state rate.
- 17. Each program must have a formal evaluation component and must submit written evaluation reports describing how the program is meeting its stated goals and objectives and if not, why not.
- 18. Recovering alcoholics, hired as staff for local programs, must have maintained sobriety for at least one year. (Cit. Alcohol and Drug Dependency Advisory Council Minutes dated 7-20-72).
- 19. The local program must define in writing its own policies pertaining to transportation of clients.
- * 20. A local program should have available fiscal resources or financial support so that it can continue to operate for a reasonable length of time in case payments of these funds should cease.
- 21. Each program should provide a written periodic review of the per capita cost of care with definition of various items included. This periodic review should be submitted at least annually and should describe the cost per client for each program component, and how such costs were determined.
- 22. Each program will be required to submit minutes of its board meetings, quarterly narrative and fiscal reports concerning the expenditure of these funds, and a final report within 30 days of the end of the contract. The programs will also submit other data as may be required.
- * These items not required from city, county, city-county or multiple county government units.

STATE OF MONTANA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
APPLICATION FOR ALCOHOL SERVICE FUNDS

APPLICATION NO. _____

DATE RECEIVED _____

1. Applicant Agency
or Institution

Name _____

Address _____

Telephone _____

2. Project Director

Name _____

Address _____

Telephone _____

3 Official Authorized to sign application
(Chairman of the Board of Directors, etc.)

4. Project Title

5. Project Duration

From _____ To _____

Total Length _____

Total Amount Requested _____

6. Type of Application

Contract for Services _____

Developmental _____

Grant-in-aid _____

7. Type of Applicant

State Government Agency _____

Local Government Agency _____

Private Tax Exempt Agency _____ IRS No. _____

Private Agency _____

8. What other support will be available for any part of this project? Define and explain

This section constitutes the heart of the application. It is the applicant's detailed statement of the project -- its aims, precisely what will be done, who will be involved, and what results can be expected. Together with the project budget, it provides primary evidence for Montana Department of Health and Environmental Sciences, and Comprehensive Health Planning review of the soundness of the project, the care and planning that has gone into its formulation, and the responsibility and qualifications of the applicant and others who will be involved.

Use continuation pages if necessary for the following information:

- A. Brief statement of purpose and the objectives of the project for which funding is requested.
- B. Statement showing level and sources of all current funding for applicant agency. Attach budget, in detail, showing funds from all sources. In addition, describe all current applications or proposals for other funding, the sources and present status and how current and requested funds will be utilized.
 - (1) Provide copy of certified audit completed within 12 months of application date.
 - (2) Requests for developmental funds must be documented to verify the existence and availability of the one-third cash match.
- C. Document that the applicant agency has at least \$300,000 of liability insurance covering the total operation including the use of private vehicles and other vehicles for the transportation of clients.

9. (Cont'd)

D. Brief description of current functions of and services rendered by applicant agency, facilities and geographical area served.

E. Narrative description of proposed activity showing relationship and/or coordination with other existing alcoholism programs in that community or region. Affiliation and/or coordination with other programs should be outlined and documented with copies of written agreements.

F. Describe how the proposed project will be evaluated in terms of both number of clients served and program effectiveness.

G. Describe internal procedure for altering or changing the attached budget.

BUDGET FOR UTILIZATION OF REQUESTED FUNDS

Description	State Alcohol Services Funds	From Local Funds	Other Funds	Project Total
Salaries				
Other Compensation				
Benefits				
Contracted Services				
Supplies and Materials				
Telephone & Postage				
Travel				
Rent				
Utilities				
Repairs and Maintenance				
Other				
Equipment				
Total				

Applicants Agreement:

- A. It is understood and agreed by the applicant that any funds received as a result of this application shall be subject to the conditions, regulations, rules and policies issued by the Department of Health and Environmental Sciences for the administration of these State General Fund monies. This includes but is not limited to:
1. That funds awarded are to be expended only for the purposes and activities covered by the applicant's approved plan and budget;
 2. That these funds may be terminated in whole or in part by the Montana Department of Health and Environmental Sciences or its designee at any time;
 3. That appropriate fiscal records and accounts will be maintained and made available for audit by the Legislative Auditor of the State of Montana (Section 79-2310, R.C.M. 1947) and/or other auditor appointed by the Department of Health and Environmental Sciences, and that these records will be so maintained for a period of five years;
 4. That all data and statistics required by the Department of Health and Environmental Sciences will be provided on the schedule and in the format prescribed by the Department.

I certify, upon receipt of these requested funds, to adhere to the preceding conditions and further certify that all information contained in this application is true and complete to the best of my knowledge.

Signed _____
Official authorized to sign application
Title _____
Address _____
Telephone _____
Date _____

ASSURANCES

Nondiscrimination

1. That all services provided under the State Plan will be made available without discrimination on account of sex, duration of residence or ability or inability to pay for such services. In addition, Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d; 78 Stat. 252), which provides that no person in the United States shall, on the ground of race, color, creed, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance, is applicable to services and programs provided under the State Plan.
2. That no formula grant funds will be awarded to public or private general hospitals which have received Federal funds for alcoholic treatment programs and which refuse admission and treatment to alcoholic persons solely on the basis of their alcoholism.

All of the other required assurances as described in previous State Plans are being met by this FY 75 Plan. There have been no changes.

In addition, the FY 75 Plan does fulfill provisions required in P.L. 93-282 that the advisory council shall include representatives "of groups to be served with attention to assuring representation of minority and poverty groups"; and that the State Plan shall "set forth, ...standards (including enforcement procedures and penalties) for (a) construction and licensing of public and private treatment facilities, and (b) for other community services or resources available to assist individuals to meet problems resulting from alcohol abuse."

STAFF DEVELOPMENT

With the increase in the responsibilities of the Alcohol Services Division, it has been necessary to continually upgrade the capabilities of Division staff (see Appendix E - Job Descriptions). All Division employees have been encouraged to attend various types of training activities and have participated to the maximum that time permits. Some of the training programs have been concerned with orientation to a particular programmatic area, whereas others have been involved with topics such as program planning, administration and evaluation. Training the Division staff has undergone during the past year is as follows:

The Division administrator participated in the following educational seminars and meetings:

- Executive Seminar for State Alcoholism Planning Directors, NIAAA; Alcohol and Drug Problems Association of North America; Council of State Alcoholism Program Directors; Arlington, Virginia.
- North American Congress on Alcohol and Drug Problems; Annual Meeting of Alcohol and Drug Problems Association of North America; Council of State and Territorial Alcohol Authorities; Council of State and Provincial Alcoholism Program Directors; San Francisco, California.
- Conference of Montana Association for Social Concerns, Great Falls, Montana.
- Operational Conference on Alcohol Abuse and Alcoholism, DHEW, Salt Lake City, Utah.
- Regional Alcoholism Seminar for State Alcoholism Authorities, DHEW, Denver, Colorado.
- Presented Seminar on the Implementation of the Uniform Alcoholism Intoxication and Treatment Act to a Course in Police Science, at Eastern Montana College, Billings, Montana.
- Conference on the Prevention of Alcohol Misuse, A Working Conference of the Western Region, Long Beach, California.
- Organizational Development Conference for State Alcoholism Directors; The American Indian Commission on Alcohol and Drug Abuse, NIAAA; and the Indian Health Service, Denver, Colorado.
- State Prevention Coordinator Program, National Center for Alcohol Education, Arlington, Virginia.
- A panelist and resource person at the Fifth Annual Conference of Wyoming Human Resources Confederation, Evanston, Wyoming.

One or more of the Division staff participated in the planning of, or attended the following educational seminars and formal courses:

- Workshop on Proposed Accreditation Standards for Alcoholism Programs, JCAH, Denver, Colorado.
- Area Alcohol Education Training Program, National Council on Alcohol Education, Salt Lake City, Utah.
- National Conference on Evaluation, NIAAA, Washington, D.C.
- NIAAA Training Institute for Alcohol Occupational Program, New Orleans, Louisiana.
- Planning Committee for National Occupational Training Institute, New Orleans, Louisiana.
- Regional Conference of Alcoholics Anonymous.
- Western Branch Public Health Association Meeting, State Dept. of Health and Environmental Sciences, Helena, Montana.
- NIAAA Training Institute for Alcohol Occupational Program, Arlington, Virginia.

- National Council on Alcohol Education Training Institute For State Alcohol Prevention Coordinators, Washington, D.C.
- Montana Health Association Annual Meeting, Missoula, Montana.
- Western Region Indian Alcoholism Training Center.
- Operational Conference on Alcohol Abuse and Alcoholism, Salt Lake City, Utah.
- Regional Alcoholism Seminar for State Alcoholism Authorities, Denver, Colorado.

Within the Department of Health and Environmental Sciences, the Division has been involved in many of the ongoing activities of the Department. Some of these activities include:

- The Division administrator participated in the Program Manager's Meetings conducted by the director of the Department twice each month. He is also involved in other study committees within the Department.
- The Division holds an associate membership in the Association of Alcoholism Halfway House Programs. This membership has provided us with a most valuable resource regarding the philosophy and operation of transitional facilities such as halfway and quarterway houses.
- Staff are involved with other health professionals in discussing appropriate public health activities, and participating in seminars conducted for these groups.
- The accounting-clerk of the Division was elected to serve as one of the alternate representatives to the Department's Employees Association.
- The staff of the Division also participates in community activities related to other areas of public health and participates in various civic activities within the community of Helena.

With the Division's increased role in providing technical assistance and training for local alcohol programs in Montana, staff will continue to upgrade their knowledge and skills in order to effectively meet these needs. Staff will attend national alcohol training programs and visit nationally recognized alcohol programs, when appropriate, in order to obtain greater insight and knowledge of how other programs are handling similar alcohol related problems. This information would then be passed on to local alcohol programs through training activities and other forms of communique.

Future training courses or educational meetings staff will be attending in 1975 are:

- A training course conducted by the NIAAA Training Institute for Alcohol Occupational Programs.
- A training course sponsored by the National Council on Alcohol Education Training Institute for State Alcohol Prevention Coordinators.
- A seminar at the University of Pennsylvania on "Can Alcoholic People Ever Drink Again".
- Western Area Alcohol Education Training Program, to discuss its training activities with state authorities.
- Seminar on Accreditation Procedures conducted by JCAH.
- Seminar on Identifying and Securing Alternate Funding Sources, NIAAA, Albuquerque, New Mexico.
- Council of State and Territorial Alcohol Authorities Meeting.
- North American Congress on Alcohol and Drug Problems Meeting.
- Council of State and Provincial Alcoholism Program Directors Meeting.

A P P E N D I X

A

AGENCY: Montana Department of Health and Environmental Sciences
 Cogswell Building, Helena, Montana 59601
 John S. Anderson, M.D., M.P.H., Director

Phone: 449-2544

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Alcohol Services Division Robert L. Solomon, Administrator Phone 449-3176	FY 75 St.General Fund \$500,000. FY 75 St.General Fund \$ 45,000. FY 74 P.L. 91-616 Formula Grant (NIAAA) \$200,000. FY 75 R18-AA00118-02 Occupational Alcoholism Grant (NIAAA) \$ 41,853. FY 75 1R13AA01804-01 \$ 25,000. Prevention Grant <hr/> \$811,853.	Coordination and promotion of alcohol programming; prevention, treatment, education, research, planning, technical assistance, grant review. Occupational Alcoholism Program for state and local government and private industry. Alcohol prevention project for the state.
Laboratories Division David Lackman, Ph.D., Administrator Phone 449-2642	1974 (DOT) \$ 41,384. 1975 (DOT) \$ 46,386.	Alcohol and drug detection program for operators of motor vehicles on the public highways of Montana.

AGENCY: Galen State Hospital
 Deer Lodge, Montana 59711
 A. C. Knight, M.D., Superintendent

Phone: 693-2281

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Galen State Hospital Dr. Abad, Clinical Director		Acute detoxication, medical evaluation.
Alcohol Treatment and Rehabilitation Program Alcoholism Services Center Galen, Montana Edward Gendle, Director	State General Fund \$314,600.	In-patient treatment, counsel- ing, and rehabilitation, public and professional information, community consultation, alcoholism counselor training.

NOTE:

INFORMATION ON THIS AND SUBSEQUENT SHEETS WAS REQUESTED BY THE MONTANA ADVISORY
 COUNCIL ON ALCOHOL AND DRUG DEPENDENCY OF THE INDIVIDUAL PROGRAMS. FIGURES
 UTILIZED ARE THOSE PROVIDED BY THE PROGRAMS.

AGENCY: Northwest Montana Alcohol and Drug Information Referral Center
 30 Fifth Avenue West
 Kalispell, Montana 59901
 Harold Schutt, Director

Phone: 756-2475

COMPONENTS	SOURCES OF FUNDS - FY 74		PROGRAM ACTIVITY
Information and Referral	EEA	\$19,028.	Intermediate care
Community Development	United Way	\$10,000.	Counseling, family
Direct Client Services	County Revenue		and individual
Recovery Center	Sharing	\$ 5,000.	Information and
	Client Fees	\$ 750.	Referral
	91-616 Formula	<u>\$19,992.</u>	Community develop-
	TOTAL	<u>\$54,770.</u>	ment

AGENCY: Alcoholism Rehabilitation Association of Southwestern Montana
 324 Fuller
 Helena, Montana 59601
 Ward Hamlin, Executive Director

Phone: 442-8831

COMPONENTS	SOURCES OF FUNDS - FY 74		PROGRAM ACTIVITY
Alcoholism Information and	91-616 Formula	\$ 28,500.	Information and
Referral Center	NIAAA	\$120,707.	Referral, Public
Fuller	Local - City/		Information,
Helena, Montana 59601	County	\$ 98,760.	Education
	Other	<u>\$ 53,998.</u>	Detoxication in
	TOTAL	<u>\$301,965.</u>	Affiliated Hospital

New Horizons Treatment Center
 1015 Missoula Avenue
 Helena, Montana 59601
 Phone: 442-0790

Inpatient Treatment
 Facility
 Twenty-one Day Treat-
 ment Program

Alcoholism Information and
 Referral Center
 104 East Main, Room 316
 Bozeman, Montana 59715
 Mrs. Joy Nash, Counselor-
 Director
 Phone: 586-2090

Information and
 Referral Center
 Outreach Program

AGENCY: Frontier Halfway House
1100 Atlantic
Dillon, Montana 59725
Mrs. Lilly Weinrich, Director

Phone: 683-4305

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
	ARA	Short Term Aftercare
	Title 45	Residential Counseling
		Public Information
		Intermediate Care

ADDITIONAL INFORMATION REQUESTED
BUT NEVER RECEIVED.

AGENCY: Community Health Services for Alcoholism
603 West Porphyry
Butte, Montana 59701
Jack Charlson, Director

Phone: 792-2939

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
New Directions Halfway House	ARA	Counseling, Aftercare,
	EEA	Information & Referral
225 South Idaho	Model Cities	Intermediate Care
(Old) St. James Hospital	Vocational	Facility
Butte, Montana 59701	Rehabilitation	Speakers Bureau
Phone: 723-9003	Patient Fees	
	Deer Lodge County	
	for Anaconda	
	TOTAL	
Alcoholism Information and Referral Center of Anaconda		Information and Referral
6th and Oak St.		
Anaconda, Montana 59711		

AGENCY: Rimrock Foundation
804 North 29th Street, Suite 201
Billings, Montana 59101
Gary Bounous, Director

Phone: 252-2542

COMPONENTS	SOURCES OF FUNDS -FY 74	PROGRAM ACTIVITY
	United Way \$ 69,000.	Outpatient Counsel-
	DOT \$ 20,000.	ing, Referral,
	Client Fees \$ 10,000.	Public Informa-
	NIAAA \$ 34,000.	tion, Individual
	<u>TOTAL \$133,000.</u>	Counseling, Group
		Therapy, Employ-
		ment Counseling,
		Marriage Counseling,
		DWI Program,
		Demonstration Grant,
		new treatment unit
		hospital component.
		Intermediate Care
		Counseling.

Big Sky Halfway House
28 Burlington Avenue
P. O. Box 645
Billings, Montana 59103
Harold Selvig, Director
Phone: 252-9864

AGENCY: Miles Recovery Center
P. O. Box 114
Miles City, Montana 59301
Leland Blazer, Director

Phone: 232-2681

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
	91-616 Formula \$4,200.00	CLOSED AND DISSOLVED
	OEO \$1,000.00	12/31/74
	Private \$ 317.75	
	County \$3,000.00	
	Client Payments \$ 920.00	
	<u>TOTAL \$9,437.75</u>	

AGENCY: Action for Eastern Montana
Hagenston Building
Glendive, Montana 59330
Phil Sullivan, Executive Director

Phone: 365-3364

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Ron Hjelmstad Alcohol Counselor c/o Sheridan County Library Plentywood, Montana 59254	NIAAA \$71,775. 12/1/72 - 11/30/74	Counseling, information and referral
Jack Pollari Alcohol Counselor c/o Action for Eastern Montana Hagenston Bldg. Glendive, Montana 59330		Counseling, information and referral
Herb Sukat Alcohol Counselor P. O. Box 889 Glasgow, Montana 59230		Counseling, information and referral

AGENCY: Cascade Council on Alcoholism
920 4th Avenue North
Great Falls, Montana 59401
Wayne Jacobson, Chairman of the Board

Phone: 727-2512

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Providence Resocialization Grants Center 920 4th Avenue No. Great Falls, Montana 59401 Paul Davis, Jr., Director Phone: 727-2512	Routine Services \$61,828. Donations \$ 9,639. Miscellaneous \$ 3,657. TOTAL \$132,124.	Information and referral, community education Intermediate care Treatment and rehabili- tation of Alcoholics

DWI Program

AGENCY: Hill-Top Recovery Center
1020 Assiniboine
Havre, Montana 59501
Danny Peressini, Director

Phone: 265-9665

COMPONENTS

SOURCES OF FUNDS - FY 74

91-616 Formula	\$20,298.
NIAAA	\$48,400.
United Way	\$ 5,000.
Jaycees	\$ 200.
Local City/County	<u>\$21,290.</u>
TOTAL	\$95,188.

PROGRAM ACTIVITY

Information and
referral
Community education
Follow-up counseling
Intermediate care
Treatment and re-
habilitation of
alcoholics
Outreach

Satellite Counselor
Shelby, Montana

AGENCY: Blackfeet Alcoholism Program
Box 426
Browning, Montana 59417
Leo Kennerly, Sr., Director

Phone: 338-7178

COMPONENTS

SOURCES OF FUNDS - FY 74

NIAAA	\$40,000.
IHS	<u>\$34,800.</u>
TOTAL	\$74,800.

PROGRAM ACTIVITY

Prevention, treatment,
rehabilitation,
information referral,
counseling
Detoxication

AGENCY: Flathead Alcoholism and Drug Abuse Information Center
2117 Main, P. O. Box 270
Ronan, Montana 59864
Harold Campbell, Director

Phone: 676-0441

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Flathead Tribal Alcoholism Program Ronan, Montana	NIAAA \$135,000. Tribal Grant \$ 6,500.	Counseling, outreach, referral, follow-up Intermediate Care
Crisis Center and Detox Unit St. Luke's Hospital Ronan, Montana	IHS \$ 44,560. 91-616 Formula 2,496.	Detoxication Unit and Staff
Information & Referral Center Sanders County	91-616 Formula <u>1,428.</u> TOTAL \$189,984.	Information, referral, counseling

AGENCY: Fort Peck Reservation Alcoholism Program
P. O. Box 307
Poplar, Montana 59255
Melvin Eagleman, Sr., Director

Phone: 768-3852

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Halfway House	NIAAA \$58,223. IHS \$70,000. Private \$20,000. Donations <u>\$ 1,500.</u> TOTAL \$149,723.	Counseling, information, referral, intermediate care, Thrift Shop, Outreach Detoxication Prevention

AGENCY: Rocky Boy Alcoholism Program
Rocky Boy Route
Box Elder, Montana 59521
Clifford Sutherland, Director

Phone: 395-2736

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
	NIAAA	Counseling, informa-
	IHS	tion, referral, educa-
		tion, Halfway House
	TOTAL	

AGENCY: Fort Belknap Alcoholism Program
Fort Belknap Agency
Harlem, Montana 59526
Stephen Fox, Director

Phone: 353-2731

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
	NIAAA	Counseling, informa-
	IHS	tion, referral
	Voc.Rehab.	Halfway House
	BIA	Detoxication at
	CETA - Title	Indian Health
	III	Hospital
	TOTAL	

AGENCY: Helena Indian Alliance
P. O. Box 1196
Helena, Montana 59601
Leo Pocha, Director

Phone: 442-9334

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

NOT CURRENTLY FUNDED

AGENCY: North American Indian Alliance
72 East Park Plaza
Butte, Montana 59701
Wayne J. Stein, Director

Phone: 723-4361

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

Indian Alcoholism
Counseling

NIAAA

\$42,385.

Education, counseling -
individual and family

AGENCY: Montana Indian Commission on Alcohol and Drug Abuse
 Cisel Hall - E. M. C. Box 570
 Billings, Montana 59101
 Sweeney R. Windchief, Director

Phone: 252-7269

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
	91-616 Formula \$ 28,500.	Compilation of data.
	NIAAA Grant \$143,165.	Identifying the needs
	10/1/74 - 9/30/75	priorities, and current
		status of programs con-
		cerning Indian alcoholism
		and drug abuse within
		the state.
		Assistance to Indian
		communities for the
		planning, development,
		and funding of Indian
		alcoholism and drug
		abuse programs on the
		local levels.
Morningstar, Inc.	NIDA \$367,000.	Demonstration Grant
	9/1/74 - 8/30/77	& Treatment (Drugs).
	TOTAL \$538,665.	

AGENCY: Northern Cheyenne Alcoholism Program
 P. O. Box 173
 Lame Deer, Montana 59043

Phone: 477-0381

COMPONENTS	SOURCES OF FUNDS - FY 74	PROGRAM ACTIVITY
Alcoholism Center	NIAAA \$ 59,512.	Intermediate care,
	Private 600.	counselling, informa-
	Service Agencies 2,500.	tion, referral,
	IHS 32,500.	Outreach
	TOTAL \$ 95,112.	Detoxication

AGENCY: Crow Reservation Alcoholism Program
c/o Community Action Program
Crow Agency, Montana 59022
Harold Stone, Director

Phone: 638-2938

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

NIAAA	\$33,000.
IHS	<u>35,000.</u>
TOTAL	<u>\$68,000.</u>

Counseling, information,
referral, detoxication

AGENCY: Great Falls Indian Education Center
P. O. Box 2532
Great Falls, Montana 59401

Phone: 761-3165

APPROVED FOR FUNDING - NIAAA

AGENCY: Missoula City-County Health Department
Courtthouse - 3rd Floor Annex
Missoula, Montana 59801
Kit Johnson, M.D., Health Officer

Phone: 728-4510

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

Research, planning

AGENCY: Cascade City-County Health Department
1130 17th Avenue South
Great Falls, Montana 59405
Don Pizzini, Health Officer

Phone: 761-6700

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

91-616 Formula \$6,558.30

Developmental funds to
conduct a survey of need,
determination of their
role

AGENCY: Rosebud County Alcohol Program
Courthouse
Forsyth, Montana 59327
Bob MacConnel, Alcohol Counselor

Phone: 356-2670

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

Alcohol Services

Division	\$ 7,600.
Rosebud County	<u>3,800.</u>
TOTAL	\$11,400.

Counseling, information
and referral

AGENCY: Billings American Indian Council
Billings Urban Indian Alcoholism Center
1626 Maurine Street
Billings, Montana 59101

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

APPROVED FOR FUNDING - NIAAA

AGENCY: Missoula Indian Alcohol and Drug Services
417 West Front - P. O. Box 1197
Missoula, Montana 59801
Gary Horse Capture, Director

Phone: 721-2700

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

NIAAA	\$65,000.
Lutheran Social	
Services	<u>2,000.</u>
TOTAL	\$67,000.

Counseling, information
and referral

AGENCY:

COMPONENTS

SOURCES OF FUNDS - FY 74

PROGRAM ACTIVITY

ALCOHOLISM PROGRAM RESOURCES

Action for Eastern Montana
Eastern Montana Alcohol & Drug Program
Hagenston Building
Glendive, Montana 59330
Phil Sullivan, Executive Director

Ron Hjelmstad
Alcohol Counselor
c/o Sheridan County Library
Plentywood, Montana 59254

Jack Pollari
Alcohol Counselor
Hagenston Building
Glendive, Montana 59330

Herb Sukat
Alcohol Counselor
Box 889
Glasgow, Montana 59230

Alcoholism Rehabilitation Association of
Southwestern Montana
324 Fuller Avenue
Helena, Montana 59601
Ward Hamlin, Executive Director

Bozeman Problem Drinking Center
1st National Bank Building, Room 317
Bozeman, Montana 59715

Cascade City-County Health Department
1130 17th Avenue So.
Great Falls, Montana 59405
Don Pizzini, Health Officer

Community Health Services for Alcoholism
603 West Porphyry Street
Butte, Montana 59701
Jack W. Charlson, Executive Director

Anaconda Information & Referral Center
of Anaconda
6th and Oak
Anaconda, Montana 59711

Frontier Halfway House
1100 S. Atlantic
Dillon, Montana 59725
Lilly Weinrich, Director

Hill-Top Recovery, Inc.
1020 Assiniboine
Havre, Montana 59501
Danny Peressini, Director

Missoula City-County Health Department
Courthouse Annex
Missoula, Montana 59801
Kit Johnson, M.D., Health Officer

Providence Resocialization Center
920 4th Avenue North
Great Falls, Montana 59401
Paul Davis, Jr., Director

Rimrock Guidance Foundation
804 North 29th Street
Billings, Montana 59101
Gary C. Bounous, MSW, ACSW, Director

Big Sky Halfway House
28 Burlington Street
P. O. Box 645
Billings, Montana 59103

Mailing Address for Big Sky Halfway House:

Big Sky Halfway House
c/o Rimrock Guidance Foundation
804 North 29th Street
Billings, Montana 59101

Northwest Montana Alcohol & Drug Information
Referral Center, Inc.
30 Fifth Avenue
Kalispell, Montana 59901
Harold Schutt, Director

Rosebud County
Bob MacConnel
Alcoholism Counselor
Forsyth, Montana 59327

INDIAN ALCOHOL PROGRAMS

Montana Indian Commission on Alcohol
and Drug Abuse
Cisel Hall - E.M.C. Box 570
Billings, Montana 59101

Billings American Indian Council
Billings Urban Indian Alcoholism Center
1626 Maurine Street
Billings, Montana 59101

Blackfeet Alcoholism Program
Box 426
Browning, Montana 59417

Crow Alcoholism Project
Crow Agency, Montana 59022

Flathead Alcoholism & Drug Abuse
Information Center
Box 270
Ronan, Montana 59864

Fort Belknap Alcoholism Program
Fort Belknap Reservation
Harlem, Montana 59526

Fort Peck Reservation Program
Box 307
Poplar, Montana 59255

Great Falls Indian Education Center
P. O. Box 2532
Great Falls, Montana 59401

Missoula Indian Alcohol & Drug Services
417 W. Front
P. O. Box 1197
Missoula, Montana 59801

North American Indian Alliance
72 East Park Plaza
Butte, Montana 59701

Northern Cheyenne Alcoholism Program
P. O. Box 173
Lame Deer, Montana 59043

Rocky Boy Alcoholism Program
Rocky Boy Route
Box Elder, Montana 59521

COMPREHENSIVE HEALTH PLANNING AGENCIES

REGION I

Economic Development Association of Eastern Montana
P. O. Box 338
Sidney, Montana 59270
Richard Eudy, Areawide Director

REGION II

North Central Montana Health Planning Council, Inc.
424 Main Street
Shelby, Montana 59474
Levi Taft, Planner Coordinator

REGION III

South Central Regional Health Planning Council, Inc.
1245 North 29th Street
Billings, Montana 59101
James M. Toner, Executive Director

REGION IV

Southwestern Areawide Health Planning Council, Inc.
324 Fuller Avenue
Helena, Montana 59601
James H. Foley, Executive Director

REGION V

Northwestern Montana Areawide Health Planning Council, Inc.
127 East Main - Box 516
Missoula, Montana 59801
Ed Mahn, Executive Director

MENTAL HEALTH CENTERS BY MENTAL HEALTH REGIONS

REGION I

Eastern Montana Regional Mental Health Center

Administrative Office

Executive Building

Miles City, Montana 59301

Phone: 232-1687

Don Hay, M.D., Psychiatrist II, Director of Medical & Clinical Services

(Counties served: Custer, Garfield, Carter, Fallon and Prairie)

Plentywood Satellite Office

c/o Sheridan County Library

Plentywood, Montana 59254

Phone: 765-2155

Counties served: Daniels, Sheridan, and eastern Roosevelt

Glendive Satellite Office

Glendive Medical Center

P. O. Box 715

Glendive, Montana 59330

Phone: 365-2922

Larry Olson, Guidance & Counseling, Psychologist II

Counties served: Dawson, Wibaux, Richland and McCone

Malta Satellite Office

Malta, Montana 59538

Phone: 654-1606

Bill Jones, Psychologist I

County served: Phillips

Glasgow Satellite Office

137 3rd Street South

Glasgow, Montana 59230

Phone: 228-9340

Kay Dorr, Guidance & Counseling Psychologist

Counties served: Valley, Roosevelt, Sheridan and Daniels

Forsyth Satellite Office

Forsyth, Montana 59327

Phone: 356-2606

Ron Mogen, Guidance & Counseling Psychologist I

Counties served: Rosebud and Powder River

REGION II

North Central Montana Regional Mental Health Center
Holiday Village
10th Avenue South
Great Falls, Montana 59401
Phone: 761-2100
Evan Crandall, Program Director

Cut Bank Satellite Office
c/o Memorial Hospital
Cut Bank, Montana 59427
Phone: 938-4138
Robert Wolfe, Psychiatric Social Worker

Havre Satellite Office
Northern Montana Hospital (east)
Havre, Montana 59501
Phone: 265-9639
Monty Kuka, Ph.D., Clinical Psychologist

REGION III

South Central Montana Regional Mental Health Center
Administrative Office
1245 North 29th Street
Billings, Montana 59101
Phone: 252-5658 (Centrex: 122-2354)
Bryce G. Hughett, M.D., Regional Director

Hardin Satellite Office
619 West Division
Box 408
Hardin, Montana 59034
Phone: 665-1049
Steve Mincer, M.A., Psychologist II

Red Lodge Satellite Office
202 South Hauser
Red Lodge, Montana 59068
Phone: 446-2500
Lan Bauer, Ed. D., Guidance & Counseling, Psychologist II

Ryegate Satellite Office
Golden Valley County Courthouse
Ryegate, Montana 59074
Phone: 568-2231
M. Saunders, M.A., Psychologist

REGION III (con't.)

Lewistown Satellite Office

211 South High

Box 44

Lewistown, Montana 59457

Phone: 538-3026

Robert Van Griethuyson, Ph.D., Psychologist

Peggy Huff, Community Mental Health Nurse

Roundup Satellite Office

Wall Building - Room 105

c/o General Delivery

Roundup, Montana 59072

Phone: 323-1142

Ron Holland, M.Ed., Guidance & Counseling

Psychologist I

Columbus Satellite Office

P. O. Box 891

Stillwater Community Hospital

Columbus, Montana 59019

Phone: 322-5834

David T. Beans, M.S., Psychologist II

Big Timber Satellite Office

Sweet Grass Community Hospital

Big Timber, Montana 59011

Phone: 932-2132

David T. Beans, M.S., Psychologist II

Harlowton Satellite Office

304 Division Street

Edison Building

Harlowton, Montana 59036

Phone: 632-4508

M. Saunders, M.A., Psychologist

REGION IV

Southwest Montana Regional Mental Health Center

Administrative Office, Silver Bow Annex

Continental Drive

Butte, Montana 59701

Phone: 723-3447

Rod Newman, Program Director

Helena Satellite Office

324 Fuller Avenue

Helena, Montana 59601

Phone: 442-0640

Francine Larson, M.D., Psychiatrist

Katherine Gallagher, Psychologist

REGION IV (con't.)

Livingston Satellite Office

Livingston, Montana 59047

Phone: 222-3332

Phillip Russell, Clinical Psychologist

REGION V

Western Montana Regional Mental Health Center

Administrative Office

Fort Missoula

Missoula, Montana 59801

Phone: 543-5177 (Centrex: 125-5021)

Clark Anderson, Program Director

Kalispell Satellite Office

704 South Main Street

Kalispell, Montana 59901

Phone: 756-9065

Herman Androes, Assistant Program Director

Libby Satellite Office

321 Mineral Avenue

Libby, Montana 59923

Phone: 293-6513

Donald Snyder, Psychologist

Ronan Satellite Office

Drawer E

Ronan, Montana 59864

Phone: 676-8500

Gordon Gerrish, Ph.D., Psychologist

Thompson Falls Satellite Office

Box 562

Thompson Falls, Montana 59873

Phone: 827-3641

William Harris, Psychologist

Hamilton Satellite Office

186 South Third Street

Hamilton, Montana 59840

Phone: 363-1051

Frank Erickson, Psychiatric Social Worker

ALCOHOL AND DRUG COUNTERMEASURES LABORATORY
TOXICOLOGY UNIT, LABORATORY DIVISION
MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
FY 1974

Summary of Workload:

1. Analyses to determine blood alcohol level = 3591 (1782 were done in the Lab. and 1809 on Alco-Analyzer Units in the field).
2. Tests for the identification of substances = 81
3. Drug screens on body fluids = 80. (The total for both - the above listed 1 and 2 - for FY 1973 was 37).
4. Staff member testified as an expert witness in court 28 times.

Detailed Activity of the Unit and the Alco-Analyzers (Direct breath-alcohol machine):

1. SM-7, Sobermeters and blood bottles were supplied to all requesting law enforcement agencies and blood bottles to requesting non-law enforcement agencies (coroners, hospitals, clinics, etc.).
2. In October 1973, 25 law enforcement officers attended an operator-supervisor school in Helena.
3. The machines in the police stations were inspected and all are in good working order and show good maintenance and care by the operator-supervisors of the units.
4. Additional simulators were purchased to provide two for each unit, one to be used for the standard and the other for a back-up and to use in the proficiency testing program. The proficiency of each unit and the average proficiency of the State is given in the accompanying tables.

ALCO-ANALYZER USE BY LOCATION FOR FISCAL YEAR 1974

<u>CITY</u>	<u>NO. OF TESTS</u>	<u>NO. > 0.10</u>	<u>NO. OF REFUSALS</u>	<u>UNIT PROFICIENCY</u>
Billings	279	266	64	.008
Kalispell	258	256	18	.004
Bozeman	220	207	20	.002
Missoula	204	196	22	.004
Helena	134	131	62	.004
Great Falls	130	130	39	.004
Wolf Point	124	121	20	.004
Havre	111	98	26	.005
Glasgow	95	93	20	.004
Glendive	68	63	20	.004
Shelby	60	57	2	.007
Miles City	57	57	3	.003
Lewistown	46	44	14	.005
Butte	21	20	2	.005
TOTALS	1809	1739	*332	** .004

*Note the high number of refusals. Even with a refusal, Alco-Analyzer and the Implied Consent Law are working.

**The average deviation from a known value of the 14 Alco-Analyzer Units in the State is 0.004. This is well below the acceptable limit, as per Department of Health and Environmental Sciences Regulation (MAC Sec. 16-2.26 (1)-S2600) of 0.010.

ALCOHOL ANALYSES IN THE LABORATORY

Tests for Law Enforcement Agencies

	<u>NO. OF TESTS</u>	<u>NO. 0.10</u>
BREATH	951	900
BLOOD	736	582
URINE	<u>45</u>	<u>44</u>
TOTALS	1738	1526

Tests for Non-Law Enforcement Agencies

BLOOD	44	31
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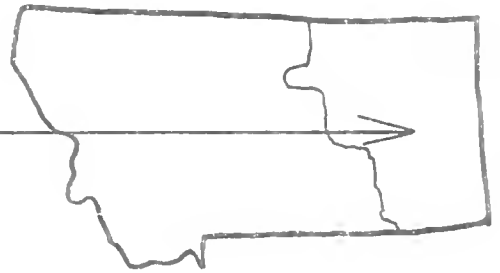
TOTAL BLOOD ALCOHOL TESTS FOR THE PROGRAM

Alco-Analyzers	1809	1739
Laboratory	<u>1782</u>	<u>1557</u>
TOTAL	3591	3296

ACTION

for Eastern Montana

Hagenston Building
Glendive, MT 59330



October 30, 1974

Mr. Robert Solomon
Administrator
Alcohol Services Division
DHES,
Cogswell Building
Helena, MT 59601

Dear Bob:

The enclosed information is in response to your letter of Sept 4 requesting material for the 1975 State Plan, which was forwarded to me by Rich Eudy, planner for EDA/Comp. Health. I feel compelled to offer some explanation regarding the lack of specificity in the goals and objectives.

In the 1974 Eastern Montana Plan we set forth what we saw as the tasks to be accomplished based upon known needs and the results of the attitudinal survey. The part that was lacking, and is still lacking to some extent, is by what means and by whom these tasks were to be accomplished. Many of these answers will have to be provided by the counties themselves, and until they make the decision as to what agency will be providing alcoholism services within their county and come up with a county plan, these questions will remain unresolved. Hopefully, all this can be decided in time for the 1976 State Plan.

As you know, our agency has decided against continuing to attempt to be the direct service providing agency. This puts the responsibility for deciding who will do what back on the various counties or districts. We feel that they should write individual plans for services. Our intention is to assist them not only in their planning, but in actually putting their programs into operation. This way, they will be taking responsibility for dealing with alcohol problems in their communities, rather than passing the buck to the State or to the Federal Government.

At this time, the Glasgow Hospital appears to be investigating possible uses for their building should they move, and is not actually involved in in-depth planning for a treatment center. The Court School in Wolf Point intends to continue, and their primary desire is to assist in developing other court school and DWI programs

throughout the State. The Miles City group has defined their goals and objectives, and these are included here. Rosebud County will submit a proposal to you shortly which they hope will result in a contract between them and DHES to provide services through the County Health Department. Several other counties are interested and you should be hearing from them within the next few months. Our own priorities are attached. This is all the concrete information on plans for alcoholism services that I have available at this time, along with the feeling that things are happening in this part of the State and may take shape rapidly between now and the beginning of the next fiscal year. Hopefully, all this will be in a direction that will result in effective delivery of services from here on out.

If you have specific questions about the enclosed material, please call.

Sincerely,

A handwritten signature in cursive script, reading "Phil Sullivan".

Phil Sullivan, Director
Eastern MT. Alcohol &
Drug Program

PS:prg

ENCL:

cc: Rich Eudy

ADDENDUM TO EASTERN MONTANA AREA PLAN
FOR CHEMICAL ABUSE
PREVENTION, TREATMENT, AND REHABILITATION
1975

PRIORITIES:

1. Finalize a contract between Rosebud County and Department of Health and Environmental Sciences for county alcoholism services. This will serve as a model of one method of providing services through an existing public agency for other counties.
2. Apply to Department of Health and Environmental Sciences for \$28,500 of PL-616 formula funds to be allocated according to population to the counties, districts, or consortiums of counties on the basis of their application and agreement to develop and implement plans for alcoholism services.
3. Apply for permission to use carryover funds from the current program year for the purpose of operating a regional alcoholism coordinating office to assist in developing and coordinating services and activities.
4. Carry out an intensive series of meetings with local authorities resulting in designation of the county health department (or other agency) as the lead agency for alcoholism services and planning, and defining roles and responsibilities for the service providers of that county.
5. Assign existing program staff to the counties or districts under the supervision of their designated alcoholism authority to help them develop and implement their local programs, with the expectation that the counselors will become part of the county or district program.
6. Continue to assist in developing and negotiating contracts for provision of alcoholism services between designated local agencies and Department of Health and Environmental Sciences, and planning to fill major gaps in services (such as in-patient and residential treatment) on a regional or district basis.

MISSION: To reduce the impact of alcohol related problems and illnesses upon the community, the family, and the individual.

GOALS:

- A. (1) Alter community attitudes and drinking practices (long-term) by (2) increasing awareness, knowledge and understanding (long-term) utilizing (3) a continuing program of public awareness and education in the schools and the communities (short-term) carried out (4) under the leadership of the local public health departments in conjunction with other appropriate agencies and organizations (short-term), (5) including local councils and volunteer groups (short-term).
- B. (1) Insure the availability of comprehensive and continuous alcoholism services (long-term) by (2) developing community resources, training and educating in roles and responsibilities (intermediate-term) and (3) establishing alcohol service delivery system (intermediate-term) so that (4) residents of the community accept and make meaningful use of such services (long-term).

- C. (1) Develop leadership, authority and organization (long-term) within the existing structure of the counties and districts by (2) designating such responsibility for planning and coordination to county health departments (short-term) or (3) district health departments (intermediate-term) and (4) establishing an eastern Montana regional alcoholism coordinating office (short-term) for the purpose of coordinating local, district, regional and state planning, assessment, research and operation.

FINAL DRAFT

STATE ALCOHOLISM PLAN FOR THE SIXTH CULTURAL REGION COMPRISED
OF ON-GOING INDIAN ALCOHOLISM PROGRAMS IN THE STATE OF MONTANA:

This date, 21 January, 1975, the Montana Indian Commission on Alcoholism and Drug Abuse, Incorporated being the representative body of all the ongoing Indian Alcoholism Programs in the State of Montana is hereby submitting this final version of the Indian input into the overall comprehensive State Alcoholism Plan.

The Montana Indian Commission on Alcoholism and Drug Abuse has been recognized by the following agencies as the representative voice of all alcoholism efforts in the State of Montana as it pertains to each Indian Community regardless if urban or reservation.

Each Reservation & Urban Governmental Unit
Inter Tribal Policy Board
Tri-State Tribes Incorporated
American Indian Commission on Alcoholism and Drug Abuse

State Governor's Office
Department of Health and Environmental Sciences

Basic to the premise of the recognition of the Montana Indian Commission on Alcoholism and Drug Abuse is the fact that the epidemiological factor of the depth and extent of the Disease Alcoholism in the Montana Indian Community demands new, innovative, and creative approaches to the resolution of the problem. As tradition non-Indian programmatic emphases in the areas of treatment, rehabilitation, prevention, planning, and information have proven to be ineffectual and inadequate, the mandate from which we henceforth operate will be to identify, utilize, and maximize traditional and cultural approaches of our Indian People in combatting this Disease.

As the total commitment of resources of the Department of Health and Environmental Sciences has been and will continue to be minimal, we will utilize that commitment as a seed to be nurtured into a total comprehensive approach that will hopefully determine the success or failure of our efforts in combatting alcoholism in the Indian Community of Montana.

With the share of the State Formula money that will be forthcoming from this State Alcoholism Plan, the Sixth Cultural Region will mobilize, coordinate, and solicit all sources of revenue and services from other state agencies, federal sources, private foundations, and local resources in sponsoring a unified front in addressing that terrible health problem as it now exists.

The Montana Indian Community has identified the following areas as priorities demanding concerted efforts during the course of the next program year.

- a. Comprehensive Program Planning
- b. Special Treatment Alternatives
- c. Special Rehabilitation Programming
- d. Certification Procedures & Standards
- e. Evaluation procedures, Standards & Alternatives
- f. Localized Training
- g. Special Interest Priorities:

- Indian Women
- Indian Youth
- Indian elders
- Indian Schools & Students
- Colleges & Indian Students'
- Penal Institutions
- Indian Summer School on Alcohol Studies
- Governmental Indian Liaison

Specific Reference to the above mentioned with a brief narrative follows:

Comprehensive Program Planning: It is the combined desire and programmatic planning that will be initiated to insure that each Indian alcoholism Program in the State of Montana will attain and achieve local and state-wide Indian standards that prove effective and relevant for that local communities alcoholics and their immediate and extended family unit. eg. Some of the Indian Programs in the State of Montana do not have access to a residential care facility.

Special Treatment Alternatives: It will be the mandate of the combined programmatic efforts of all the Indian Alcoholism Programs in the State of Montana to identify and utilize traditional and cultural approaches to the treatment of alcoholism. eg. Medicinemen should retain a renewed position of respect and use as an alternative to other treatment modalities.

Special Rehabilitation Programming: Rehabilitation and or job training will be revised to increase the linkage between the past and the realities of today and the future. eg. Leadership training as it pertains to the Indian Community could be taught with skills acquisition to becoming a community leader taking increased emphasis.

Certification Procedures & Standards: In lieu of non-relevant standards for the certification of counselors, facilities and/or programs, the Montana Indian Commission on Alcoholism and Drug Abuse has been given

the mandate of designing and implementing relevant standards for localized programming in each of the Indian Communities. Process will be coincidental to the design and implementation of those standards.

Evaluation Procedures, Standards & Alternatives: It is the expectation of the Montana Indian Community that the Montana Indian Commission on Alcoholism and Drug Abuse will identify in general-objective levels, the criteria by which the local programs utilizing the technical expertise of the Montana Indian Commission on Alcoholism and Drug Abuse will adjudge the overall effectiveness and excellence of their local program.

Localized Training: With the Official Defunding of the regional training institutions authorized to training alcoholism program personnel, it is imperative that a training design be developed to implement the mandates of the emphasis of tradition and culture with a realistic view of the dual responsibility of skills acquisition and academics. As the National Institute on Alcohol Abuse and Alcoholism is presently in the process of funding special traditional and cultural training programs, it is our expectation to follow suit and to design a similar model to be supported on all governmental levels.

Special Interest Priorities:

A workshop to be planned and implemented to identify and share special concerns and problems of the Indian Woman Alcoholic.

A workshop will be planned and implemented to similarly address the needs of the Indian Youth.

Our Indian Elders who for so long have remained neglected and unheard as in the Non-Indian Community will be approached and listened to for advice and counsel. Also needs and problems of this special group will be identified and special programming and programming priorities will be addressed.

School/Colleges and the Indian Students that attend them are in need of new and assertive positive informational and preventive programs as a buffer to alcohol abuse.

Penal Institutions and local jails in Montana have an alarming rate of Indian Inmates that committed crimes under the influence of alcohol. We must not forget these Indian People.

An Indian Summer School on Alcohol Studies will be a forum for the coming year that will enable us to share the positive in roads that we are making and are hoping to achieve in our battle with the disease-alcoholism.

An Indian Liaison with the Governors Office to inform the chief executive of the program operations of the alcoholism programs in the Montana Indian Community.

As stated, these are and will continue to be the priorities of the Montana Indian Community in regard to alcohol Programming for the forthcoming year. To these priorities will pledge our maximum time, effort, energies, and prayers.

Northwestern Montana Areawide Health Planning Council

EDWARD F. MAHN

Director

Box 516, 127 E. Main

Missoula, Mt. 59801

Phone (406) 543-8271
or 728-7800

October 28, 1974

TO: Robert Soloman, Administrator
Alcohol Service Division
Department of Health
Cogswell Boulevard
Helena, Montana 59601

FROM: Jeanne Sheils

RE: Update of Region V Alcohol Plan

In reviewing the Alcohol Plan for Region V, we feel that very little revision is necessary at this time. Our goals remain the same, although several objectives have been reworded.

Goal I, Objective A-2 formerly read: "County committees should be set up in each county." This has been modified to "Multi-county committees." Correspondingly, any further mention of singular county committees has been changed to multi-county.

Goal III, Objective A has been reworded to further stress the need for a preventative approach to alcoholism.

Please note also that throughout the update, Region I has been changed to Region V.

Although advances have been made in the field of alcoholism in this region, due to increased funding, crossing county lines, and better agency cooperation, they have not been significantly substantial to require a revision of the Plan.

Further, we feel the goals of the Plan have been promoted and have been instrumental in guiding the approach to alcoholism. Because the thrust of our plans and the recommendations for implementation remain the same, we are hopeful that the 1974 Plan, with its minor revisions, will continue to be effective.

The priorities in the "needs assessment" were ranked as follows:

1. Need for education regarding alcohol and alcoholism.
2. Need special help for the drinking driver, the driving-while-intoxicated individuals, and DWI education.
3. Need for follow-up for alcoholic after treatment at Galen.
4. Need for early detection and treatment for the alcoholic, and counseling for families of alcoholics.
5. Need for proper and comprehensive facilities to detoxify the alcoholic.
6. Need for agency cooperation.
7. Need for better understanding and cooperation between the professional and AA.
8. Need for transportation to Galen.

I. Goal One

We will attempt to minimize fragmentation of services, and to effect agency cooperation in an attempt to integrate existing services to more efficiently utilize those services which already exist, and to make accessible to the alcoholic client those services which will most benefit him.

A. Objective: To achieve agency cooperation and better understanding between the professionals who treat alcoholics and problem drinkers and Alcoholics Anonymous (AA).

1. It is proposed that a coordinator be hired to help integrate existing agencies/services in Region V.
2. Multi-county committees should be set up throughout the areawide. The coordinator would be useful as a facilitator in organizing county committees.

II. Goal Two

We will attempt to alleviate the suffering of the alcoholic or problem drinker and his/her family by making him aware that alcoholism is a disease, and a treatable disease, and to reduce the stigma accompanying such disease. (Disease-stigma also covered under Goal 3 outline)

A. Objective: To provide help for the alcoholic--make him aware of his problem. To help in early detection and treatment for the alcoholic, and counseling for families of alcoholics.

1. A North Dakota mental health association concept, with some revisions, may be useful to this end.

Alcohol Plan, Region I, continued

2. To promote the concept of occupational assistance for the alcoholic; to help assist alcoholics and problem drinkers, as well as those with financial, credit, and marital problems; to facilitate early intervention when alcoholism problems are indicated.
- B. Objective: Follow-up for individuals released from Galen should become a standard part of the individual's re-entry into the community, taking care to safeguard the rights of the individual.
1. The individual should be encouraged by Galen personnel to request follow-up services when he/she returns to the community, and be given a choice of the agencies/ services which can/will provide such a service.
- C. Objective: Special help for the drinking driver, the driving-while-intoxicated individual, and DWI education
1. Utilize various syllabi which are available, including Hennepin County Alcohol Safety Action Project and DWI Counterattack.
 2. Publicization of the argument that temporary loss of driving license is a trivial hardship when set against the loss of life on the highway.
 3. The Liquor Control Board should enforce the existing law (Sec. 4:100 of Montana Alcohol Code) which makes it a misdemeanor to serve liquor to an individual who is intoxicated.

III. Goal Three

We will attempt to educate the community regarding the nature of alcoholism and the role the general public plays in the rehabilitation of the alcoholic; to lessen the stigma of the disease in the eyes of the general public; and to make the community aware that its attitude is important in any treatment attempt.

- A. Objective: To provide education regarding alcohol and alcoholism, with an increased emphasis on preventative education.
1. Schools
 2. Public Information Campaign
 3. Community Publicity Committee
 4. Speakers' Bureau

IV. Goal Four

We will attempt to maximize utilization of resources to such an extent that services can/will be provided to as large a number of individuals as possible who suffer from the effects of problem drinking and alcoholism.

A. Objective: To provide adequate emergency treatment and detoxification facilities within each county.

1. The multi-county committee should investigate the possibility of detoxification units, utilizing existing facilities in area hospitals.
2. Decision on facilities appropriate for care of acutely intoxicated individuals.

North Central Montana Health Planning Council

424, MAIN STREET

SHELBY, MONTANA 59474

Seri Taft, Executive Director

October 17, 1974

Mr. Robert Solomon, Administrator
Alcohol Services Division
Capitol Station
Helena, Montana 59601

Dear Mr. Solomon:

Enclosed is a copy of the proposed areawide alcohol services plan for 1975 for Comprehensive Health Planning District II.

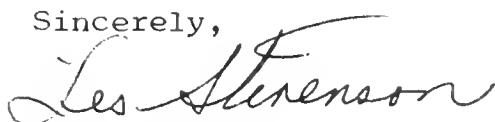
This is a proposed addendum to the 1974 plan and has not been presented to the Council's Board of Directors for approval, but I do not anticipate any major changes of the present proposal.

This plan was developed by the Areawide Alcohol Committee with input from Hill Top Recovery Center and Providence Resocialization Center.

Any comments you may have regarding this plan will be appreciated.

A full and final copy of this area plan will be forwarded to you upon adoption of same by the Board of Directors.

Sincerely,

A handwritten signature in cursive script that reads "Les Stevenson".

Les Stevenson

ADDENDUM TO 1974 PLAN

1975 PLAN FOR COMPREHENSIVE SERVICES FOR ALCOHOLISM ALCOHOL ABUSE PREVENTION, TREATMENT AND REHABILITATION NORTH CENTRAL MONTANA HEALTH PLANNING COUNCIL

INTRODUCTION:

The following addendum to the 1974 areawide plan for alcohol abuse and alcoholism prevention, treatment and rehabilitation, as approved by the Board of Directors of North Central Montana Health Planning Council in December, 1973, is an up-date for continuation of the plan for the year 1975.

This up-date establishes an overall goal and priorities for 1975. These goals and priorities were developed through cooperative efforts of county committee representatives and services providers who were invited to a planning meeting held in Great Falls on September 23, 1974.

It should be noted that the up-date is in regard to the nine counties of Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton and Toole.

Review and comment regarding this addendum will be available to the county committees before presentation to and approval by the Board of Directors.

GOAL:

Assure that direct services are available and accessible to all residents of the area who are in need of such services and that services be flexible to meet individual need.

ACTIVITIES:

1. Continued efforts to further develop the expertise and strength of local county committees.
2. Development of individual county priorities consistent with areawide goal.
3. Development of individual and multi-county referral and coordination of services for maximum utilization of resources.
4. Expand the membership of the areawide Addictive Diseases Committee to include representation from each of the nine county committees.
5. Promote centralization of administrative management and coordination of services on an individual and/or multi-county basis when practical.

PRIORITIES: (The following priorities are not listed in their order of importance but are viewed as area of equal prime concern)

I. Transportation.

Transportation to and from treatment facilities is a primary problem for most communities in the North Central area. The question of who is responsible for providing transportation in a health related atmosphere will be addressed on an individual and areawide base. Secondly, getting those responsible for transportation to accept and carry out their responsibilities will be a primary activity throughout the area.

II. Education:

The education is used here to address three basic functions:

- A. Inform the general public of the problems and complexity of alcoholism to develop community understanding and support.
- B. Promote early detection and prevention of alcoholism and alcohol abuse.
- C. Identify for those in need of assistance the location and accessibility of treatment and other services.

These educational activities will be carried out within the area with each community emphasizing the elements viewed as most needed in their community.

III. Special Training:

Special training can be defined as a support of education but deals with more specifics and is addressed to specific individuals and/or groups. The area will involve three specific groups in workshop-seminar type training sessions to increase their knowledge in the area of alcoholism. The groups to be involved are:

- A. Support Services Staff: The staff of agencies such as Welfare, County Health, Vocational Rehabilitation and Hospitals who have personal contact with the alcoholics and their families will be invited to participate in an areawide workshop. The purpose of this workshop will be to assist them in developing better techniques and procedures in assisting the alcoholics and families.
- B. Law Enforcement: The police and sheriff departments, city and county attorneys, justices of the peace, police judges and district judges will be given the opportunity to participate in an areawide workshop. The purpose of this workshop will be to discuss alternative methods of dealing with alcohol abusers and alcoholics.
- C. County Committee Members: Continual training will be emphasized to further develop the planning, problem identification and resource utilization expertise of the local county committees.

IV. Referral and Coordination:

Each community within the area will be working towards establishing a referral system that will insure a continuum of service without interruptions.

V. Follow-up:

A follow-up program is seen as a most important factor of services. If follow-up is not maintained then preceding services are, in many cases, wasted time, effort and resources. Each community will be working to establish the availability of follow-up services.

VI. Counselors:

Staffing is the primary component of any program. The communities of the area will be developing methods of obtaining the availability of qualified alcohol counselors for their community. This service can be developed on a shared multi-county basis or individually as the needs indicate. The primary factor is to have a qualified counselor available when needed.

Complete roster of committees members and minutes of committee meetings are on file with the State office.

SOUTH CENTRAL REGIONAL HEALTH PLANNING COUNCIL, INC.

1245 N. 29th • Billings, Montana 59101 • Ph. 252-3851

January 29, 1975

Robert L. Solomon, Administrator
Alcohol Services Division
State Department of Health
and Environmental Sciences
Helena, MT 59601

Re: Areawide Alcoholism Plan Update

Dear Bob:

I am enclosing a copy of the results of our Areawide Alcoholism Plan (Update) meeting which was held July 2, 1974. This should provide you with information on where we stand to date on priorities.

We have, unfortunately, not been progressing as quickly as we expected. Most of the delay has been caused by the confusion surrounding a possible Alcoholism Consortium in this area. I expect this situation to clear up shortly.

Sincerely,



James M. Toner
Executive Director

JMT/msw

Enclosure



SOUTH CENTRAL REGIONAL HEALTH PLANNING COUNCIL, INC.

1245 N 29th • Billings, Montana 59101 • Ph. 252-3851

TO: Representatives Attending the Areawide Alcoholism Plan Meeting
FROM: Jeanne Boland, SCRHPC Staff
DATE: July 2, 1974
RE: Areawide Alcoholism Plan Meeting (Results)

An Areawide Alcoholism Plan meeting was held Wednesday, June 26, at 2:00 p.m. in the Mental Health Center. The purpose of the meeting was to 1) review and, if appropriate, validate recommendations of the Areawide Alcoholism Plan; 2) prioritize needs relating to alcoholism; 3) suggest guidelines for the review of any proposals received so that county needs may be met and 4) review any proposals which had been submitted.

Areawide Alcoholism Plan Recommendations Changes

Following a discussion of the eleven recommendations, a twelfth recommendation was added "Education in grade school and high school." The tenth recommendation was amended to read, "There should be development of a service delivery system which maximizes a continuum of care and provides for ongoing evaluation."

Schematic

After discussing alternate means of prioritizing the recommendations, the following schematic was agreed upon. The group felt Educational Services and a Service Delivery System were the most important recommendations. Realizing that the different counties in the Region were at different stages of development in the two priority recommendations described, the group listed the components in order of importance and implementation stage. (See attachment.)

After deciding that Educational Services and a Service Delivery System were the two main priorities, the committee felt that in-service training was a necessary and first component of both of the recommendations. In-service training preceeds (1, left side of chart) changing the Community Climate of opinion to one of understanding and acceptance of the alcoholic and (1, right side of chart) a therapeutic, non-punitive referral system. Also, in-service training should add names to the resource list developed in the counties.

Once the climate of opinion has been altered, people need a system whereby alcoholism literature and educational materials are readily accessible. The media was included because of the under-utilization of the newspapers in the counties. The use of county newspapers could be coordinated with some of the national commercials on radio and television.

The group felt that education had to begin in grade school; consequently efforts should first be directed there and then begin programs in high school. Lastly, the group felt educational services should be

toward the families of alcoholics and others directly affected by the alcoholic. Businessmen who employ alcoholics was one group specifically mentioned.

Under the Service Delivery System, a therapeutic, non-punitive referral system was the first step. Part of this system was a Regional Resource List developed by pooling each county's resource lists. A detoxification system was the second priority in a Service Delivery System. The word "system" was emphasized. A detoxification system would include all of the county hospitals which provide for detoxification, in addition to a non-medical detoxification center in Billings. The third component of a Service Delivery System was the Supportive Services. The list includes counseling services, intermediate care facilities, A.A. and others. The supportive services were not prioritized.

An on-going effort falling under both Educational Services and a Service Delivery System was "Review and Administrative". The first priority was a uniform record-keeping system. The second was a communication system, whereby County taskmembers and others interested in alcoholism could share ideas and stay in contact with each other. The third component was the need to assess service effectiveness and evaluation of programs.

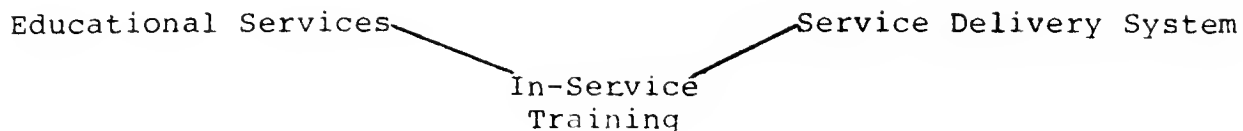
Guidelines

When the necessity for developing guidelines for the review of proposals was discussed, the group recommended that they provide input to SCRHPC's Executive Committee for review of any proposals. State Advisory Committee Member, Mona Sumner, stated that the Alcohol and Dependent Drug Bureau was developing guidelines for the review of alcoholism proposals. The group then recommended that a letter be drafted to Bob Solomon requesting the guidelines as soon as possible.

Association of Alcoholism Programs Proposal

Mr. Brian DeRosches presented a proposal for an "umbrella" corporation to assist in the application of grants, coordination of alcoholism programming, and implementation of the Areawide Alcoholism Plan. Representatives at the Areawide Alcoholism Plan meeting were asked to send comments to him at Deaconess Hospital by July 12.

The meeting was adjourned at 4:45 p.m.



1. Community Climate of Opinion
2. A practical system could be developed so alcoholism literature and educational materials will be readily accessible to each county, including utilization of the media.
3. Education in Grade School
4. Education in High School
5. Families of the alcoholic and others directly affected by the alcoholic

1. Therapeutic, non-punitive referral system. A regional Resource List and flow chart will be developed at the county level and then the regional level.
2. Detoxification System
3. Support Services
 - a. counseling services
 - b. intermediate care
 - c. A.A.
 - d. etc

Review and Administrative

1. Uniform record keeping system
2. Communications system
3. Service effectiveness and evaluation

12-5-74

NIAAA RESEARCH GRANTS PAID IN FY 1974

INSTITUTION CITY AND STATE	1ST FUTURE	2ND FUTURE	3RD FUTURE	4TH FUTURE	5TH FUTURE	6TH FUTURE	BUDGET PERIOD	FY	IRG	TOTAL AWARD
MONTANA-WYOMING INDIAN CM ALC & DRUGS AS BILLINGS MONTANA	89,496	27,695	0	0	0	0	10-01-74 09-30-75	74	ASPI	796,625
PROGRAM CLASS SS-A	143,795	0	0	0	0	0	MONTANA INDIAN COMMISSION ON ALCOHOLISM			2,773,333
1	143,795	0	0	0	0	0	1 R18 AA00579-01A1 MONTANA INDIAN COMMISSION ON ALCOHOLISM		ASPI	143,165
ACTION FOR EASTERN MONTANA GLENDIVE MONTANA	0	0	0	0	0	0	5 R18 AA00616-02 EASTERN MONTANA ALCOHOLISM PROGRAM	74	ASPI	71,775
PROGRAM CLASS SS-P	0	0	0	0	0	0				
1	0	0	0	0	0	0	5 R18 AA00616-02 FORT PECK ALCOHOLISM PROGRAM	74	ASPI	71,775
FORT PECK TRIBAL EXECUTIVE BOARD POPLAR MONTANA	0	0	0	0	0	0	10-01-73 09-30-75	74	ASPI	66,446
PROGRAM CLASS SS-A	0	0	0	0	0	0				
FORT PECK TRIBAL EXECUTIVE BOARD POPLAR MONTANA	0	0	0	0	0	0	3 R18 AA00108-02S1 FORT PECK ALCOHOLISM PROGRAM	74	ASPI	23,766
PROGRAM CLASS SS-A	0	0	0	0	0	0				
2	0	0	0	0	0	0	5 R18 AA00653-02 NORTHERN CHEYENNE TRIBAL COUNCIL	74	ASPI	90,212
NORTHERN CHEYENNE TRIBAL COUNCIL LAME DEER MONTANA	0	0	0	0	0	0	12-01-73 11-30-75	74	ASPI	119,024
PROGRAM CLASS SS-A	0	0	0	0	0	0				
1	0	0	0	0	0	0				119,024

12-05-74

NIMRA RESEARCH GRANTS PAID IN FY 1974									
INSTITUTION	BY STATE, INSTITUTION AND PRINCIPAL INVESTIGATOR	PRINCIPAL INVESTIGATOR	GRANT NUMBER	PUDGET PERIOD	FY	IRG			
CITY AND STATE	DEPARTMENT	PROJECT TITLE	5TH FUTURE	6TH FUTURE					
1ST FUTURE	2ND FUTURE	3RD FUTURE	4TH FUTURE	5TH FUTURE	6TH FUTURE				
FORT BELKNAP COMMUNITY COUNCIL HARLEM MONTANA PROGRAM CLASS SS-A	MCNE	FOX, STEPHEN, SR	0	0	0	ASRI	39,928		
HILL COUNTY COMMUNITY ACTION, INC. HAYES MONTANA PROGRAM CLASS SS-P	MCNE	BAUER, HERBERT J	0	0	0	ASRB	96,800		
CROW TRIBAL COUNCIL CROW AGENCY MONTANA PROGRAM CLASS SS-A	MCNE	STCNE, HAROLD	0	0	0	ASRI	96,600		
CHIPPEWA CREE BUSINESS COMMITTEE BOX ELDER MONTANA PROGRAM CLASS SS-A	MCNE	MITCHELL, PAUL	0	0	0	ASRI	37,200		
CONFEDERATED SALISH AND KOOTENAI TRIBAL DIXON MONTANA PROGRAM CLASS SS-A	MCNE	CAMPBELL, HAROLD	0	0	0	ASRI	25,000		
NORTH AMERICAN INDIAN ALLIANCE SUTTE MONTANA PROGRAM CLASS SS-A	MCNE	STEIN, WAYNE JOHN	0	0	0	ASRI	26,375		

SOURCE: IMPAC/DRT, SAB, DBG IRS PROGRAM B304

NIAAA RESEARCH GRANTS PAID IN FY 1974

INSTITUTION CITY AND STATE	DEPARTMENT	PRINCIPAL INVESTIGATOR	GRANT NUMBER	BUDGET PERIOD	FY	1ST FUTURE	2ND FUTURE	3RD FUTURE	4TH FUTURE	5TH FUTURE	6TH FUTURE	TOTAL AWARD
BLACKFEET TRIBAL BUSINESS COUNCIL BROWNING MONTANA PROGRAM CLASS SS-A	NONE	KENNELLY, LEO, SR	5 R18 AA00892-02 BLACKFEET ALCOHOLISM PROGRAM	03-01-74 02-28-75	74	39,186	0	0	0	0	0	42,385
RIMROCK GUIDANCE FOUNDATION BILLINGS MONTANA PROGRAM CLASS CA	NONE	BOUNOIS, GARY C	1 R18 AA01653-01 ALCOHOLISM TREATMENT PROGRAM & REFERRAL SYSTEM	10-01-74 09-30-75	74	30,913	0	0	0	0	0	40,000
MONTANA ST DEPT OF HLTH & ENVNMTL HELENA MONTANA PROGRAM CLASS CP	NONE	SCHLOMCH, ROBERT I	1 R18 AA01804-01 ALCOHOLISM PREVENTION COORDINATOR	07-01-74 06-30-76	74	30,913	0	0	0	0	0	40,000
MONTANA ST DEPT OF HLTH & ENVNMTL HELENA MONTANA PROGRAM CLASS AA	NONE	SCHLOMCH, ROBERT L	5 R18 AA00118-03 MONTANA STATE OCCUPATIONAL ALCOHOLISM PROGRAM	06-01-74 05-31-75	74	0	0	0	0	0	0	34,436
NEBRASKA STATE DEPARTMENT OF PUBLIC INTN LINCOLN NEBRASKA PROGRAM CLASS CP	DIVISION ON ALCOHOLISM	NGPTEH, JOHN W	1 R18 AA01794-01 NEBRASKA ALCOHOLISM PREVENTION PROGRAM	07-01-74 06-30-76	74	0	0	0	0	0	0	57,500
NEBRASKA STATE DEPARTMENT OF PUBLIC INTN LINCOLN NEBRASKA PROGRAM CLASS AA	NONE	NGPTEH, JOHN W	5 R18 AA00131-03 NEBRASKA OCCUPATIONAL ALCOHOLISM PROGRAM SERVICES	06-01-74 05-31-75	74	213,894	0	0	0	0	0	51,973

A P P E N D I X

B

P R E T E S T I N G P A M P H L E T S

1. Check with professional staff who will be using the material as to its acceptability, accuracy, group it will be used with, and why they plan to use it.
2. From the above information, determine the target group (group it will be used with).

Ask ten members of target group to read pamphlet. Ask them to note words or phrases they do not understand. Note the length of time it takes them to read it. Ask if they found it interesting.

If there is a great deal of disagreement with the pamphlet, or if the target group does not understand it, the information will be brought back to the professional staff and appropriate changes will be made.

3. From information under 1, determine objectives (why they plan to use pamphlet).

Develop some questions based on these objectives and interview target group. Again, if there is marked disagreement or if the target group members cannot follow directions, understand material, or ask questions to clarify material in pamphlet, note this information and discuss with professional staff. It may require changing materials, obtaining a new pamphlet, or developing another method for education of the target group.

For a rapid and educated guess about the reading level of the material, a Flesch formula may be used. If the target group averages ten years of schooling, the reading level should be at about eight years of education. This procedure makes it more likely that the material will be read.

A P P E N D I X

C



Department of Health and Environmental Sciences
STATE OF MONTANA HELENA, MONTANA 59601

ALCOHOL AND DRUG DEPENDENCE BUREAU

John S. Anderson M.D.
DIRECTOR

April 24, 1974

TO: Alcoholism Program Directors
Community Mental Health Centers
Full-time Health Departments

The training of alcoholism program directors, counselors, and board members has been a priority utilization for a sizeable portion of the state alcoholism formula money that have been available to Montana.

In the past, funds have been made available for travel, per diem, registration fees and other costs related to training experiences. The demand for this financial assistance has steadily increased and has made it necessary to establish certain guidelines. These guidelines will be followed for all training assistance requests, beginning May 6, 1974.

These guidelines are as follows:

1. Requests must be received by this Bureau at least 1 month prior to the start of the actual training experience.
2. The request must be in writing from the program director and must indicate justification for the specific training and that the trainee has authorization to be away from his program duties for the period of training. Program directors requesting training funds must have the written approval of the chairman of their Board of Directors.
3. The letter of request should indicate how much local money will be made available for the desired training. Multiple funding of training will be considered top priority.
4. A written summary of the training experience will be expected by this Bureau within 15 days after the training. This must be a detailed report and not a re-statement of the agenda. The financial assistance, if approved, will be made available after this report is received by the Bureau. The contract will be void and no payment will be made unless the report is received within the 15 day period.

Requests for training assistance must follow these guidelines. Your assistance in this matter will expedite the process. Please let me know if you have any questions.

Sincerely,

Robert L. Solomon
Bureau Chief

RLS:nb

BOARD TRAINING

Sponsored by Alcohol Services Division of the Montana Department of Health and Environmental Sciences

The Alcohol Services Division of the Montana Department of Health and Environmental Sciences is developing a training program (workshop) for board members of local alcohol program governing bodies. This workshop will be designed to fit the needs of each individual governing body (board) in Montana. The needs of each alcohol program will be determined through a discussion with the board members and the executive director. The length of the workshop may be one and one-half days or less, depending upon the needs of each program.

The purpose of the workshop is to provide the board members with a working knowledge of the responsibilities and procedures required of a governing body. Emphasis will be placed on communication skills, general knowledge of alcohol and various kinds of treatment modalities, responsibilities, roles, and procedures of a governing authority, and responsibilities and roles of program staff.

The instructors for the workshop will be staff from Alcohol Services Division and other consultants. The training in the workshop will consist of lectures, group discussions, work sessions, committee reports, and audio-visual materials.

The general content of the workshop will be:

- I. Overview of Training Session
- II. Communication Skills
 - A. Basic dimensions of communication
 - B. Communication activities
- III. Alcohol and Alcoholism
 - A. Effects of alcohol abuse
 - B. Alcoholism
 - C. Treatment modalities
 - D. Program modality
- IV. Governing Authority
 - A. Rules of thumb
 - B. Role and responsibilities of a board
 - C. Specific responsibilities of officers and members
 - D. Responsibilities of members
 - E. Functioning of boards (nuts & bolts)
- V. Organization vs. Staff
 - A. Executive Director
 - B. Staff
 - C. Volunteers
- VI. Community Resources

A P P E N D I X

D

1977-74 302

HOUSE BILL NO. 909

INTRODUCED BY FASBENDER, CAMPBELL, DRISCOLL, SWANBERG, MARKS
MCKITTRICK, GREELY

AN ACT ADOPTING CERTAIN PROVISIONS OF THE UNIFORM ALCOHOLISM
AND INTOXICATION ACT, INCREASING THE TAX ON ALCOHOLIC BEVERAGES
TO CREATE A FUND FOR THE PROGRAMS AUTHORIZED BY THIS ACT, AMENDING
SECTIONS 4-201, 4-240, 4-324, 11-927, AND 94-8-105, R.C.M. 1947,
AND REPEALING SECTIONS 4-164 AND 69-6202, R.C.M. 1947.

This bill was received by
the Governor this 16 day
of March 1974

Thomas L. Judge
Governor

By Frank Murray

Approved 3-25-74
Thomas L. Judge
Governor



STATE OF MONTANA
DEPARTMENT OF SECRETARY OF STATE

March 25 1974
AT 3:00 P M
Frank Murray
SECRETARY OF STATE
BY Glenn Woodard
DEPUTY

HOUSE BILL NO. 909

INTRODUCED BY FASBENDER, CAMPBELL, DRISCOLL, SWANBERG, TARKS,
MCKITTRICK, GREELY

IN THE HOUSE

SECOND REGULAR SESSION

January 17, 1974	Considered read and referred to Committee on Judiciary.
February 15, 1974	Committee recommends bill be pass as amended. Report adopted and referred to Bills Committee for printing.
February 19, 1974	Reported correctly printed. Report adopted. Referred to second reading.
February 20, 1974	Recommended favorably by Committee of the Whole as amended. Report adopted and referred to Bills Committee for engrossing.
February 21, 1974	Reported correctly engrossed. Report adopted and referred to calendar for third reading. On motion rules suspended and bill placed on third reading this day. Read three several times and passed. Title and history agreed to. Transmitted to the Senate for its concurrence.

IN THE SENATE

February 22, 1974	Considered read and referred to Committee on Taxation.
February 28, 1974	On motion taken from Committee on Taxation. Referred to Committee on Public Health, Welfare and Safety.

March 8, 1974

Committee recommend that bill be concurred in. Report adopted. Bill referred to second reading.

On motion placed on second reading for consideration this day.

Committee of the Whole recommend that further action be indefinitely postponed. Report adopted.

On motion segregated from report of Committee of the Whole.

Passed consideration.

March 9, 1974

Committee of the Whole recommend bill be concurred in as amended. Report adopted. Referred to calendar for third reading.

On motion rules suspended. Bill placed on calendar for third reading this day.

Read third time and concurred in as amended. Title and history agreed to. Returned to House for concurrence in Senate amendments.

IN THE HOUSE

March 11, 1974

Referred to second reading for concurrence in Senate amendments.

March 12, 1974

Senate amendments concurred in by Committee of the Whole. Placed on calendar for third reading.

March 13, 1974

Senate amendments concurred in on third reading. Referred to Bills Committee for enrolling.

Reported correctly enrolled.

AN ACT ADOPTING CERTAIN PROVISIONS OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT, INCREASING THE TAX ON ALCOHOLIC BEVERAGES TO CREATE A FUND FOR THE PROGRAMS AUTHORIZED BY THIS ACT, AMENDING SECTIONS 4-201, 4-240, 4-324, 11-927, AND 94-8-105, R.C.M. 1947, AND REPEALING SECTIONS 4-164 AND 69-6202, R.C.M. 1947.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. There is a new section to be numbered 69-6211, R.C.M. 1947, which reads as follows:

69-6211. Declaration of policy. It is the policy of the state of Montana to recognize alcoholism as an illness and that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

Section 2. There is a new section to be numbered 69-6212, R.C.M. 1947, which reads as follows:

69-6212. Definitions. For purposes of this act:

* (1) "alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private

agency meeting the standards prescribed in section 69-6216(1) and approved under section 69-6216;

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the department or providing treatment under this act through a contract with the department and approved under section 69-6216;

(4) "department" means the department of health and environmental sciences provided for in section 32A-601, R.C.M. 1947;

(5) "incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment;

(6) "incompetent person" means a person who has been adjudged incompetent by the district court;

(7) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(8) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics and intoxicated persons.

Section 3. There is a new section to be numbered 69-6213,

R.C.M. 1947, which reads as follows:

69-6213. Powers of department. The department may:

- (1) plan, establish, and maintain treatment programs as necessary or desirable;
- (2) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this and other states for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;
- (3) do other acts and things necessary or convenient to execute the authority expressly granted to it; and
- (4) provide treatment facilities for alcoholics and intoxicated persons.

Section 4. There is a new section to be numbered 69-6214, R.C.M. 1947, which reads as follows:

69-6214. Duties of department. The department shall:

- (1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals and provide technical assistance and consultation services for these purposes;
- (2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals

interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the department of institutions and board of pardons in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the department of education, the superintendent of public instruction, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to

alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the state's comprehensive health plan;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with the department of justice in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and

intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the governor an annual report covering the activities of the department.

Section 5. There is a new section to be numbered 69-6215, R.C.M. 1947, which reads as follows:

69-6215. Comprehensive program for treatment. (1) The department shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons.

(2) The program shall include:

(a) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(b) inpatient treatment;

(c) intermediate treatment; and

(d) outpatient and followup treatment.

(3) The department shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 69-6218 to 69-6221. Treatment may not be provided at a correctional institution except for inmates.

(4) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(5) The department shall prepare, publish, and distribute annually a list of all approved public and private treatment

Facilities.

Section 6. There is a new section to be numbered 69-6216, R.C.M. 1947, which reads as follows:

69-6216. Facility standards -- inspections -- approvals. (1) The department shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

(2) The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(3) The department shall maintain a list of approved public and private treatment facilities.

(4) Each approved public and private treatment facility shall file with the department on request, data, statistics, schedules, and information the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

(5) The department, after holding a hearing in accordance with the Administrative Procedure Act, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for

failure to meet its standards.

(6) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(7) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this act.

Section 7. There is a new section to be numbered 62-6217, R.C.M. 1947, which reads as follows:

62-6217. Acceptance for treatment; rules. The department shall adopt rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In adopting the rules the department shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to

require inpatient treatment.

(3) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

Section 8. There is a new section to be numbered 62-6218, R.C.M. 1947, which reads as follows:

62-6218. Voluntary treatment of alcoholics. (1) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian, or other legal representative may make the application.

(2) Subject to rules adopted by the department, the administrator of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to departmental rules, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(3) If a patient receiving inpatient care leaves an approved

public treatment facility, he shall be encouraged to consent to appropriate out-patient or intermediate treatment. If it appears to the administrator of the treatment facility that the patient is an alcoholic who requires help, the department shall arrange for assistance in obtaining supportive services and residential facilities.

(4) If a patient leaves an approved public treatment facility, with or against the advice of the administrator of the facility, the department shall make reasonable provisions for his transportation to another facility or to his home. If he has no home he shall be assisted in obtaining shelter. If he is a minor or an incompetent person the request for discharge from an inpatient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he was the original applicant.

Section 9. There is a new section to be numbered 62-6219, R.C.M. 1947, which reads as follows:

62-6219. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (1) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police.

(2) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons. The police, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. No entry or other record may be made to indicate that the person taken into custody under this section has been arrested or charged with a crime.

(3) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

(4) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility (1) once he is no longer incapacitated by alcohol, or (2) if he remains incapacitated by alcohol for more

than forty-eight (48) hours after admission as a patient, unless he is committed under section 69-6220. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

(5) A person who is not admitted to an approved public treatment facility and is not referred to another health facility, may be taken to his home. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(6) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

Section 10. There is a new section to be numbered 69-6220, R.C.M. 1947, which reads as follows:

69-6220. Emergency commitment. (1) An intoxicated person who (a) has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or (b) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(2) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section,

directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within two (2) days before the certificate's date and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(3) Upon approval of the application by the administrator of the approved public treatment facility; the person shall be brought to the facility by a peace officer, health officer, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection (5).

(4) The administrator of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(5) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than five (5) days. If a petition for

involuntary commitment under section 69-6221 has been filed within the five (5) days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than ten (10) days after filing the petition.

(6) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within twenty-four (24) hours after commitment by the department, who shall provide a reasonable opportunity for the person to consult counsel.

Section 11. There is a new section to be numbered 69-6221, R.C.M. 1947, which reads as follows:

69-6221. Involuntary commitment of alcoholics. (1) A person may be committed to the custody of the department of institutions by the district court upon the petition of his spouse or guardian, a relative, the certifying physician, or the chief of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he (a) has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (b) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to

the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two (2) days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the department is not eligible to be the certifying physician.

(2) Upon filing the petition, the court shall fix a date for a hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian if he is a minor, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(3) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall have a right to have a licensed physician of his own choosing examine him and testify on his

behalf, and if he has no funds with which to pay such physician, the reasonable costs of one such examination and testimony shall be paid by the county. The person shall be present unless the court believes that his presence is likely to be injurious to him; he shall be advised of his right to counsel and, if he is unable to hire his own counsel, the court shall appoint an attorney to represent him at the expense of the county. The court shall examine the person in open court, or if advisable, shall examine the person in chambers. If he refuses an examination by a licensed physician and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the department of institutions for a period of not more than five (5) days for purposes of a diagnostic examination.

(4) If after hearing all relevant evidence, including the results of any diagnostic examination by the department of institutions, the court finds that grounds for involuntary commitment have been established by clear and convincing evidence, it shall make an order of commitment to the department of institutions. It may not order commitment of a person unless it determines that the department of institutions is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(5) A person committed under this section shall remain in

to the custody of the department of institutions for treatment for a period of thirty (30) days unless sooner discharged. At the end of the thirty (30) day period, he shall be discharged automatically unless the department of institutions before expiration of the period obtains a court order from the district court of the committing district for his recommitment upon the grounds set forth in subsection (1) for a further period of ninety (90) days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department of institutions shall apply for recommitment if after examination it is determined that the likelihood still exists.

(6) A person recommitted under subsection (5) who has not been discharged by the department of institutions before the end of the ninety (90) day period shall be discharged at the expiration of that period unless the department of institutions, before expiration of the period, obtains a court order from the district court of the committing district on the grounds set forth in subsection (1) for recommitment for a further period not to exceed ninety (90) days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the department shall apply for recommitment if after examination it is determined that the likelihood still exists. Only two (2) recommitment orders under subsections (5) and (6) are permitted.

(7) Upon the filing of a petition for recommitment under

subsections (5) or (6), the court shall fix a date for hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (1) if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (3).

(8) A person committed to the custody of the department of institutions for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(a) in case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer in need of treatment or the likelihood no longer exists; or

(b) in case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(9) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be

represented by counsel at every stage of any proceeding relating to his commitment and recommitment, and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(10) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the department of institutions may transfer him to the private treatment facility.

(11) A person committed under this section may at any time seek to be discharged from commitment by writ of habeas corpus or other appropriate means.

(12) The venue for proceedings under this section is the place in which person to be committed resides or is present.

Section 12. There is a new section to be numbered 69-6222, R.C.M. 1947, which reads as follows:

69-6222. Records of alcoholics and intoxicated persons. (1) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(2) Notwithstanding subsection (1), the department may make available information from patients' records for purposes of research into the causes and treatment of alcoholism. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

Section 13. There is a new section to be numbered 69-6223, R.C.M. 1947, which reads as follows:

69-6223. Visitation and communication of patients. (1) Subject to reasonable rules regarding hours of visitation which the department may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel, and for continuing contact with family and friends consistent with an effective treatment program.

(2) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The administrator may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

Section 14. There is a new section to be numbered 69-6224, R.C.M. 1947, which reads as follows:

69-6224. Application of Administrative Procedure Act. The Administrative Procedure Act applies to and governs all administrative actions taken under this act.

Section 15. Section 4-201, R.C.M. 1947, is amended to read as follows:

"4-201. Interdiction -- order of -- effect. (1) Where it appears to the satisfaction of a district court that an individual lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted, the court may make an order of interdiction prohibiting the sale of liquor to him until further order; and the court shall cause the order to be forthwith filed with the department of revenue.

(2) On the making of an order for interdiction the interdicted person may forthwith deliver to the department all liquor then in his possession or under his control to be kept for him by the board until the order of interdiction is revoked or set aside, or to be purchased by the department at a price to be fixed by it. All liquor not delivered to the department under this subsection may be confiscated and forfeited to the state."

Section 16. Section 11-927, R.C.M. 1947, is amended to read as follows:

"11-927. Prevention of and punishment for disturbing the peace. The city or town council has power: To prevent and punish intoxication (subject to the limits established in section 69-6224), fights, riots, loud noises, disorderly conduct, obscenity, and acts or conduct calculated to disturb the public peace, or which are offensive to public morals, within the city or town, and within three miles of the limits thereof."

Section 17. Section 4-240, R.C.M. 1947, is amended to read as follows:

"4-240. License tax on liquor -- amount -- distribution of proceeds. The department of revenue is hereby authorized and directed to charge, receive and collect at the time of sale and delivery of any liquor under any provisions of the laws of the state of Montana a license tax of five percent (5%) of the retail selling price on all liquor so sold and delivered. Said tax shall be charged and collected on all liquor brought into the state and taxed by the department of revenue. The retail selling price shall be computed by adding to the cost of said liquor the state markup as designated by said board. Said five percent (5%) license tax shall be figured in the same manner as the state excise tax and shall be in addition to said state excise tax. The department of revenue shall retain the amount of such five percent (5%) license tax so received in a separate account. Four-fifths (4/5) of these revenues shall be distributed to the counties according to the amount of liquor purchased in each county. One-fifth (1/5) of these revenues shall be deposited in the general fund. Provided, however, in the case of purchases of liquor by a retail liquor licensee for use in his business, the department shall make such regulations as are necessary to apportion that proportion of license tax so generated to the county where the licensed establishment is located, for use as provided in section 4-241, R.C.M. 1947. The department of

revenue shall pay quarterly to each county treasurer the proportion of the license tax due each county.

The county treasurer of each county shall retain one-fourth (1/4) of said license tax, and shall, within thirty (30) days after receipt thereof, apportion the remaining three-fourths (3/4) thereof to the treasurers of the incorporated cities and towns within his county, said apportionment to be based in each instance upon the proportion which the gross sale of liquor in such incorporated city or town bears to the gross sale of liquor in all of the incorporated cities and towns in his said county."

Section 18. Section 4-324, R.C.M. 1947, is amended to read as follows:

"4-324. Tax on imported beer -- computation in case of barrels of capacity other than thirty-one gallons. A tax of three dollars (\$3) per barrel of thirty-one (31) gallons, is hereby levied and imposed on each and every barrel of beer manufactured out of this state and sold herein by any wholesaler, which said tax shall be due at the end of each month from said wholesaler, upon any such beer so sold by him during that month. As to any beer imported and sold in containers other than barrels, or in barrels of more or less capacity than thirty-one (31) gallons, the quantity content shall be ascertained and computed by the department of revenue in determining the amount of tax due, as herein provided for. An additional tax of twenty-five cents (\$0.25) per barrel is levied and imposed as provided by this


section, and such additional tax is also to be levied and imposed at the same rate upon beer manufactured within the state. The additional tax of twenty-five cents (\$.25) is to be deposited, notwithstanding sections 4-347, 4-347.1, or any other provision, in the general fund."

Section 19. There is a new section to be numbered 69-6224, R.C.M. 1947, which reads as follows:

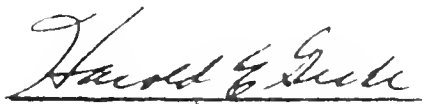
69-6224. Departmental reports to legislature. The department and the department of institutions shall achieve full implementation of the provisions of the act, as set forth in this chapter and related sections, no later than January 1, 1976. A progress report on the implementation shall be made to the 1975 legislative session. Thereafter the departments shall report, to each legislative session, on the status of the implemented act. This report, or any part thereof, may be included as the department's state plan for alcohol abuse and alcoholism.

Section 20. Sections 4-164 and 69-6202, R.C.M. 1947, are repealed.

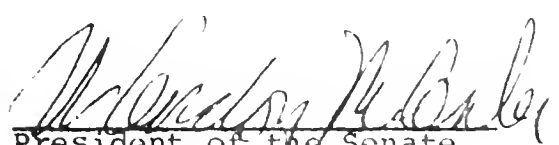
I hereby certify that the
within bill originated in
the House.



Chief Clerk



Speaker of the House
Signed this 16th day
of March, 1974.



President of the Senate
Signed this 16th day
of MARCH, 1974.

PROPOSED RULES

FOR IMPLEMENTING SECTIONS

69-6216, 69-6217 and 69-6218 R.C.M. 1947

(H.B. 909)

Montana Department of Health and Environmental Sciences

Alcohol Services Division

September 1974

(1) Purpose. The purpose of this rule is to establish minimum health and treatment standards for the approval of facilities extending treatment services to alcoholics, intoxicated persons and persons incapacitated by alcohol pursuant to Section 69-6216, R.C.M. 1947, and standards for acceptance of persons into the treatment program, and standards by which the administrator may determine which persons may be admitted to an approved public treatment facility as an alcoholic pursuant to Sections 69-6217 and 69-6218, R.C.M. 1947. Prior to approval and prior to being designated as part of the state program for treatment, each facility shall be licensed in accordance with Section 69-5203, R.C.M. 1947.

(2) Definitions. In addition to the terms defined in Section 69-6212, R.C.M. 1947,

"administrator" means the person in charge, care or control of the treatment facility and responsible for the operation of the facility.

"care" means services provided by trained nurses, aides, alcoholism helpers or counsellors.

"comprehensive treatment center" is a multi-care treatment facility for individuals wherein treatment requires continuous inpatient care with specific therapeutic functions.

"emergency facility (non-hospital)" means a facility which is advertised, announced or maintained for the expressed or implied purpose of providing individuals admitted there with short term residence, nursing, convalescent or rehabilitative care, supervision and care incidental to withdrawal from alcohol.

"halfway house" is a community based, peer group oriented, residential facility providing therapeutic services including supervision and an opportunity for re-learning social skills to assist persons to return to the community.

"license" means a certificate issued by the department to indicate the approval of a treatment facility by the department which has been found to be in full compliance with this rule.

"licensed nurse" means either a registered nurse or a licensed practical

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nurse.

"licensed practical nurse" means a nurse who is currently licensed to practice as a licensed practical nurse in Montana.

"physician" means a physician licensed by the State of Montana.

"outpatient", when used to modify a person, facility or service, means a person who is not a resident of the treatment facility.

"patient" means a person who is formally diagnosed as in need of and admitted to a treatment facility.

"person" means an individual or group of individuals, association, partnership or corporation.

"registered nurse" means a nurse who is currently licensed to practice as a registered nurse in Montana.

"resident" means any person assigned, residing or living, sleeping, eating or otherwise occupying a dwelling or rooming unit in a treatment facility.

"treatment facility" means any public or private place, establishment, building, rooming house, boarding house, lodging house, dwelling, home, farm, camp or other facility by whatever name known used to provide treatment services as an emergency and receiving facility, halfway and rehabilitation facility or comprehensive treatment center providing any or all of the following services to alcoholics, intoxicated persons, or persons incapacitated by alcohol: emergency, inpatient, intermediate or outpatient treatment.

(3) Requirements for licensure of alcohol treatment facilities. Each public or private facility providing services for alcohol treatment shall be subject to approval by the department. Said approval shall be certified by the granting of a license. The license issued annually shall be conditional to establishing and operating approved facilities in compliance with this rule.

(a) A hospital licensed by the department in accordance with the requirements of Title 69, Chapter 52, R.C.M. 1947, deemed by the department to be responsible

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and suitable shall be issued a license to establish and maintain a facility.

(b) If a treatment facility is determined to be in compliance with state requirements and applicable federal requirements, the department shall issue the license to the facility. This license shall be displayed in a conspicuous place in the facility for which it was issued.

(c) Each license shall be valid only in the possession of the person to which it is issued and shall not be subject to sale, assignment or other transfer, voluntary or involuntary, nor shall a license be valid for any location other than that for which it is issued.

(d) Each license shall be for a period of one year from the date of issue unless revoked or suspended.

(e) Each license shall be renewed annually. Each application for renewal shall be submitted on the form provided by the department not less than thirty (30) days prior to expiration.

(f) Additional data, statistics, schedules and/or information shall be filed by the applicant as may reasonably be required by the department for the purpose of determining the applicant's conformance with this rule.

(4) Operational requirements.

(a) Food service.

(i) Food shall be provided and shall be wholesome and nutritionally balanced in accordance with approved diet. Three meals or equivalent shall be served daily at regular times. Snacks of nourishing quality shall be available to residents at all times.

(ii) Food not prepared on site shall be obtained from approved sources and shall be transported and served in an approved manner.

(b) Personal hygiene.

(i) Clean clothing, drinking cups, cloth, towels, soap, toothbrushes, combs, toothpaste or tooth powder, shaving equipment and other personal articles as

required shall be available to each resident for his individual use.

(c) Medical.

(i) Medical services shall be available under the supervision of a physician, and any resident at his own expense shall have the right to consult with the physician or dentist of his own choice.

(ii) Written medical policies and procedures shall be readily available to staff. Written medical policies and procedures as to the course of action to be followed in the care of occupants having minor acute illnesses and in the event of medical emergencies including dangerous behavior shall be developed with the assistance and written approval of a physician or a representative of the medical board.

(iii) Provision for medical and surgical care shall be made with a general hospital for the provision of medical and surgical care for residents when it is needed. The facility is not required to assume responsibility for the cost of such care.

(iv) Personal observation and inquiry shall be made of each person upon admission as to chronic illness or physical disability or vermin infestation or possible contagious disease that may require medical attention. Such medical attention shall be immediately provided when necessary and no person shall be admitted who is in need of medical services for a severe physical or emotional illness including severe alcohol intoxication or its withdrawal symptoms except in a facility capable of providing the necessary services.

(v) Standard first aid equipment and supplies shall be provided and shall be available for emergency and routine use conforming to written procedures. The resident physician or the facility's advisory physician shall be consulted in the event of medical need.

(vi) Dental care shall be available for relief of pain and control of infection.

(vii) Psychiatric aid and treatment shall be made available for emergencies

or upon referral by the consulting physician.

(viii) Medications shall be handled in accordance with provisions of applicable state and federal laws and regulations.

(ix) Prescription medicines shall be prescribed, stored and delivered for use in accordance with the Montana Pharmacy, Dangerous Drug and Controlled Substances law and the Federal Controlled Substances Act as follows:

(aa) The prescription medication for use of residents shall be present only on an individual prescription basis unless the facility is equipped with a dispensary staffed by a physician.

(ab) Prescription medication shall be released to a resident who is discharged only as prescribed and on a practitioner's written authorization.

(ac) Prescription medication shall be destroyed when the label is mutilated or indistinct, the medication has deteriorated and any unused portions remain due to death or release of the resident. Discontinuance of medication is indicated by recovery of health or terminated by order of the physician.

(ad) All medication shall be stored in a secure, clean storage cabinet.

(x) Medications purchased independently by a resident or supplied by his physician or medicines used by the resident shall be stored in such a manner that the use of such materials can be restricted to self administration by the resident.

(xi) Methods for cleaning, handling and storing all supplies and equipment shall be such as to prevent the transmission of infection through their use.

(d) Responsibility.

(i) Policies and procedures shall be established at each facility to insure proper environmental and personal health conditions for protection of the health of the residents.

(ii) A routine operational maintenance program shall be conducted to keep the facility in a clean sanitary condition.

(5) Records and Reports.

(a) Residents' records: Residents' records shall be handled and stored in such a manner as to properly safeguard the confidentiality of their contents. Each resident's record shall include at least the following:

(i) Identifying and sociological data including name, age, sex, and marital status.

(ii) Dates of admission and discharge.

(iii) Records of illnesses.

(iv) Records of medical care, including physical examinations and medications taken.

(v) At least semi-monthly written progress reports on each resident by professional staff plus a termination report.

(vi) An individualized treatment plan containing both short term and long term goals.

(b) Other records and reports: The following other records and reports shall be made available for review by the department:

(i) Resident admission register.

(ii) Articles, by-laws, rules and regulations of the governing body, of minutes of meetings of the governing body, and operational policies established by the governing body of the treatment facility.

(iii) Job descriptions for personnel.

(iv) Qualifications of personnel.

(v) Copies of formal written agreements for all services not provided.

(vi) Record of menus served during the previous 30-day period.

(vii) Any other records or reports required by the department.

(c) Confidentiality: Patient record information may be maintained or disseminated, by compulsory process or otherwise, outside the patient's treatment program which collected such information, only as provided in these standards.

(i) Patient record information may be made available to qualified persons for research related to the administration of alcohol programs provided:

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(aa) that released information does not permit identification of the individuals to whom such information relates,

(ab) or that the patient voluntarily gives his written permission for release,

(ac) and subject to the confidential relationship between physician and patient.

(ii) Patient record information may be made available to authorized persons for the purpose of certification, monitoring, and evaluation of the treatment facility provided:

(aa) that the department establishes an authorized list of agencies and persons,

(ab) that in no event shall such authorized officials disseminate records which permits identification of the patient or copies of the patient record information to any unauthorized individual or agency,

(ac) that authorized officials shall not, directly or through any intermediary, disseminate, orally or in writing, such information to any individual or agency not authorized to have such information,

(ad) that it is subject to the confidential relationship between physician and patient.

(iii) A treatment facility must release patient information to the individual to whom the information pertains or to his attorney.

(iv) Officials of the treatment facility with the consent of the person under their supervision may summarize the substance of such individuals' record information for other parties at the written direction of the patient.

(v) Any individual who believes that patient record information of a treatment facility maintaining information concerning him is incorrect, shall upon satisfactory verification of his identity, be entitled to review such information in person or through counsel in the presence of a professional staff member of said

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treatment facility and to obtain a certified copy of it for the purpose of challenge, correction, or the addition of explanatory material, and to challenge, purge, delete, correct and append explanatory material.

(6) Requirements specific to non-hospital emergency and receiving facilities.

(a) A non-hospital emergency and receiving facility shall provide individuals admitted there with short term residence nursing, convalescent or rehabilitative care; supervision and care incidental to alcoholism or alcohol abuse. An emergency facility shall be a place where an alcoholic, intoxicated person or person incapacitated by alcohol can be:

(i) Sobered up in a safe environment and protected from the dangers of his drunken behavior to himself and others.

(ii) Protected from developing the sometimes life-threatening mental and physical symptoms that ensue when a habitual excessive drinker abruptly terminates his drinking.

(iii) Screened for the presence of the diversity of medical and surgical conditions that are often the consequence of drunkenness, alcoholism or both, and be referred expeditiously to a hospital for definitive diagnosis and treatment.

(iv) Provided with encouragement, advice, counselling and referral to other treatment and service facilities and agencies for help in controlling his alcohol problem if he has one.

(b) Program. Non-hospital emergency services shall be provided on a 24-hour 7-day a week basis. The facility shall have as a basic framework a written plan for the admission, care, treatment and discharge of all clients.

(i) When a person is admitted to a non-hospital emergency and receiving facility, a record shall be made of the resident's clothing and valuables and signed by the resident or sponsor and a staff member of the facility.

(ii) Upon the evaluation by personnel and examination by a physician and a determination being made that the person is intoxicated and there being adequate and appropriate treatment available in the non-hospital emergency and receiving facility, the person shall be admitted.

(iii) Counselling staff shall be available to provide appropriate evaluation, counselling and referral.

(iv) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(c) The facility staff.

(i) Around the clock coverage must be maintained seven days a week.

(ii) The minimum staff required to provide coverage for admitting, treating and discharging purposes, (e.g. at night) as opposed to necessary administrative counselling, referral, housekeeping, etc. activities depends mainly on the size of the unit and the admission rate. To admit, treat and discharge clients in all but the smallest facilities would require a minimum of two personnel present in the unit at all times.

(iii) Total staffing requirements in terms of number, classification and costs in order to accomplish all necessary functions of the facility would depend on:

(aa) The size of the unit (number of beds).

(ab) The rate of turnover of beds, which would be largely a function of duration of client stay policy.

(ac) The layout of the resident care areas (e.g. two small wards of ten beds each would require more personnel than a ward of twenty beds, especially if the wards were on different floors or unless the two wards were immediately adjacent and accessible).

(d) Personnel requirements. Depending on factors such as availability, economy, the opportunity to assist rehabilitation by employing remitted alcoholics and demonstrated effectiveness and safety, personnel

shall include, but not be limited to:

- (i) An administrator.
- (ii) An administrative assistant. (in a large facility of thirty or more beds).
- (iii) An alcoholism program specialist or coordinator (in units of twenty or more beds).
- (iv) An alcoholism counsellor, counsellor, coordinator or specialist. (There should be one counsellor for every eight residents, but this may include the administrator).
- (v) Secretarial and clerical help.
- (vi) A cook and cook's helper if the facility has its own kitchen.
- (vii) Nurses.
- (7) Requirements specific to halfway house facilities.
 - (a) Program. Supervision and services shall be provided on a twenty-four hour seven-day a week basis. The facility shall have as a basic framework a written plan for the admission, care, treatment and discharge of all clients. The following services, programs and concepts shall be provided.
 - (i) Psychiatric services may be provided through a community mental health center or through psychiatric consultation.
 - (ii) Rehabilitation may be provided in a rehabilitation center, mental health center, or through a recognized rehabilitation service.
 - (iii) Group therapy services may be provided in the residential facility by an experienced group therapist, or in a community agency which offers group therapy as part of its services.
 - (iv) Counselling staff shall be available to provide appropriate evaluation, counselling and referral.
 - (v) Recreational and social rehabilitation activities shall be planned for therapeutic purposes and shall be under the guidance of an experienced person. All residents shall be encouraged to participate in appropriate activities, both

in the residential facility and in the community. The program shall place priority on those activities which will help residents resume normal social life in the community.

(b) Consistent with his ability to pay or capacity to maintain employment, a resident shall be required to pay for services rendered within the treatment plan.

(c) In order to maintain residency and be qualified for funding for services, a resident must be formally admitted, there must be a treatment plan and client must participate in the program.

(d) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(e) Staff.

(i) Around the clock coverage must be maintained seven days a week.

(ii) A minimum staff, required to provide coverage for admitting, supervising, and discharging purposes, (e.g. at night) as opposed to necessary administrative, counselling, referral, housekeeping, etc. activities depends mainly on the size of the unit and the admission rate. To admit, supervise and discharge clients in all but the smallest facilities would require a minimum of two personnel present in the unit at all times.

(iii) Total staffing requirements in terms of numbers, classification and cost in order to accomplish all necessary functions of the facility would depend on:

(aa) The size of the unit (number of beds).

(ab) The rate of turnover of beds, which would be largely a function of duration of client stay policy.

(g) Personnel requirements. Depending on factors such as availability, economy, the opportunity to assist rehabilitation by employing remitted alcoholics and demonstrated effectiveness and safety, minimum staffing for a twenty bed center

shall consist of:

(i) An administrator.

(ii) A counsellor (smaller units may purchase counselling services).

(iii) A house manager (staffed to provide 24 hour coverage of service). The house manager need not be on duty if the administrator or counsellor is available. The house manager may include salaried resident employees.

(iv) Cook.

(v) Assistant cook.

(8) Requirements specific to comprehensive alcohol treatment centers.

(a) A comprehensive treatment center is defined as a multi-care treatment facility for persons who may be intoxicated, incapacitated by alcohol and who may or may not be alcoholic but who require continuous care and treatment with specific therapeutic functions.

(b) Program. Comprehensive treatment services shall be provided on a 24-hour 7-day a week basis. The facility shall have as a basic framework a written plan for the admission, care, treatment and discharge of all clients. The following services, programs, and concepts shall be provided.

(i) Professional personnel, facilities and equipment sufficient to carry out a program which will assist the client to regain to the limit of his or her potential his or her physical, mental, social and vocational abilities to function in society on a productive basis.

(ii) Direct basic service shall include: residence (board and room); education (alcoholism); evaluation and diagnosis (medical and psychological if required); counselling (individual and group); referral to specialized resources in the community upon release (or prior to release if appropriate) and orientation to Alcoholics Anonymous.

(iii) Returning the person to sobriety in a safe environment protected from the dangers of his drunken behavior to himself and others and also protected from

developing the sometimes life threatening mental and physical symptoms that ensue when a habitual excessive drinker abruptly terminates his drinking.

(iv) Screening for the presence of the diversity of medical and surgical conditions that are often the consequence of drunkenness, alcoholism or both and referring to other medical staff for definitive diagnosis and treatment.

(v) Group therapy.

(vi) Vocational therapy and other psychotherapeutic modalities.

(c) Staff.

(i) Around the clock coverage shall be maintained seven days a week.

(ii) The minimum staff shall be determined by the governing body and will depend on the size of the unit and the admission rate. To admit, treat, provide continuing treatment and discharge clients in all but the smallest facilities would require treatment personnel present in the facility at all times.

(iii) Total staffing requirements in terms of numbers, classification and cost in order to accomplish all necessary functions of the facility would depend on:

(aa) The size of the unit (number of beds).

(ab) The rate of turnover of beds which would be largely a function of duration of client stay policy.

(ac) Factors such as availability, economy, the opportunity to assist rehabilitation by employing remitted alcoholics and demonstrated effectiveness and safety.

(iv) There shall be sufficient qualified personnel to operate the treatment center. This does not preclude the use of patients for work assignments when the assignment is part of the treatment plan.

(v) A staff member who is qualified to supervise the clients and the center shall be on duty at all times. In addition, the administrator shall be on call and available for emergencies.

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(vi) There shall be a physician on the staff or by a contractual agreement who shall direct medical services, assist in the development of written medical policies and procedures as to the course of action to be followed in the care of clients having minor illnesses, complete necessary physical examinations and provide treatment in the event of medical emergencies.

(viii) There shall be an adequate number of qualified treatment staff members in the specialties required by the treatment regimen or regimens of a comprehensive alcoholism treatment center such as alcoholism counsellors, psychologists, social workers, psychiatrists, clergymen, etc. Their qualifications shall conform to the prevailing standards of these specialties with specific training and/or experience in the treatment of alcoholism.

(d) Personnel requirements. Staffing composition must consist of the following:

(i) Administrator.

(ii) Physician (for medical evaluations and emergency service) either on the staff or by a contractual arrangement.

(iii) Nurses (RN's or LPN's).

(iv) Counsellors.

(v) Counsellor aides if size of facility warrants.

(vi) Cook or dietitian if meals prepared on site.

(vii) Cook's assistants if meals prepared on site.

(viii) Bookkeeper if size of facility warrants.

(ix) Secretary.

(x) Other staff as needed to maintain health standards required by the department.

(9) Alcoholics--voluntary treatment in approved public treatment facility.

(a) Prior to admission of a person into an approved public treatment facility as an alcoholic, the administrator of the facility shall cause the person to be evaluated by personnel trained in the recognition of alcoholism, inebriation and

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the physical and mental complications of these conditions.

(b) The person shall be examined by a physician or, in the absence of a physician, transferred promptly to another appropriate public treatment facility or medical facility where medical examination may be obtained.

(c) A person who by evaluation and medical examination is determined to be an alcoholic shall be admitted to the approved public treatment facility if the facility can provide care and services appropriate to the person's physical, emotional and social needs.

(d) If an alcoholic is not admitted to an approved public treatment facility for the reason that adequate and appropriate treatment is not available at the facility, the administrator shall refer the person to another public treatment facility at which adequate and appropriate treatment is available.

(e) If another approved public treatment facility capable of extending treatment services to alcoholics is not readily available, the administrator shall arrange for the transfer of the alcoholic to another approved public treatment facility providing appropriate care.

(f) Approved public treatment facilities providing care and treatment shall enter into a written referral transfer agreement with:

(i) One or more general hospitals to provide for the reasonable assurance of transfer for emergency and in-patient care for residents whenever such transfer is medically necessary.

(ii) One or more community medical centers and/or private or public psychiatric hospitals that will provide for the reasonable assurance of transfer for emergency and other care for residents whenever such transfer is psychiatrically necessary.

(iii) The agreement shall provide for the expeditious transfer of persons to the hospital or psychiatric facility.

(10) Acceptance of persons into the treatment program.

(a) Voluntary treatment shall be encouraged and maintained when possible.

(b) Facilities shall admit and care for only those persons for whom they can provide care and services appropriate to a person's physical, emotional and social needs.

(c) Any restrictions, priorities or special admission criteria used during initial screening shall be applied equally to all potential admissions regardless of source of referral, source of payment, race, creed, ethnic origin or sex.

(d) A person who by evaluation and medical examination is found to require out-patient or intermediate treatment shall be initially assigned to a program providing such treatment or transferred to a facility providing the appropriate treatment. If a person is found to require in-patient treatment, such treatment shall be made available to him.

(e) A facility shall not prohibit a person from subsequent participation in a treatment program where the person has withdrawn from prior treatment or has relapsed after earlier treatment.

(f) An individualized treatment plan specifically tailored to meet the needs of each individual patient shall be prepared and maintained on a current basis for each patient.

(g) The staff of a facility shall develop an appropriate referral plan for the resident deemed necessary to effect total and complete recovery and rehabilitation. Staff shall actively assist residents to make contact with clinics, Alcoholics Anonymous, social and welfare agencies and any other agencies, or other approved treatment facilities suitable for follow-up care upon discharge from the facility.

(11) Administrative management--governing body.

(i) A facility shall have an effective governing body which is legally responsible for the conduct of the facility.

(ii) The governing body shall establish a philosophy for the service of a framework for the formulation of policies and goals.

(iii) Policy shall be in writing governing admissions, discharges, length of stay, diagnostic groups to be served, scope of services, treatment regimens, staffing patterns, recommendations for continued treatment by referral or otherwise, and provision for a continuing evaluation of the facility program.

(iv) The governing body shall be responsible for providing personnel, facilities and equipment needed to carry out the goals and objectives of the program and meet the needs of the residents.

(v) The governing body shall appoint a program administrator who is qualified to administer the program of services. Policies shall be in writing governing the qualifications and responsibilities of the administrator.

ESSENTIAL COMPONENTS OF A COMPREHENSIVE SERVICE/TREATMENT SYSTEM FOR THE ALCOHOLIC OR PROBLEM DRINKER

These are closely related to the essential services needed by Mental Health Centers in order to provide a continuum of care for patients.

In-Patient Services. This generally refers to residential treatment at an institution such as is available at Galen. It also refers to short-term in-patient treatment sometimes provided in a local hospital.

24 Hour Emergency Services. This usually refers to detoxification of the acutely ill alcoholic who will require some medical attention for his symptoms. Such services are most often given in a hospital setting, however, paramedical detoxification centers affiliated with hospitals but physically apart from them are currently being used with great success in detoxification and, most importantly, for short-term treatment of the alcoholic. Lower cost of these facilities is a decided advantage over hospitalization. Where hospitals are used for this care, it is essential that a service system be available to the patient for followup treatment.

Out-Patient Services. These services refer to the earlier detection, diagnosis and treatment, and followup of individuals with symptoms of alcoholism. This component may actually consist of several different agencies or people organized to provide the functions stated above on behalf of the alcoholic and family members. Out-patient services such as counseling of family members may result in earlier detection of the disease. Alcoholics Anonymous is also an example of an out-patient service and fulfills the followup function and, for many alcoholics, a treatment function. In order to fully meet the criteria for an out-patient component by National Institute on Alcohol Abuse and Alcoholism standards, there must be a professional component to the out-patient services. Hence, AA and the AA family groups are seen by this agency more as support services than as diagnosis and treatment services.

Intermediate Care. This component refers to care rendered the patient following detoxification and diagnosis. It may take place in several settings. It may occur immediately following hospitalization for acute alcoholism and focus on those individuals who are too ill to return immediately to homes but who do not require residential treatment or it may mean care in a halfway house setting following residential treatment for patients who need help in readjusting to a community. Ideally, Intermediate Care should address itself to both functions. However, most intermediate care services currently available in our state are halfway houses set up to provide care once a patient has been through residential treatment. In its truest sense, this type of care should be available to circumvent the need by patients for expensive residential care.

Prevention - Education. These two components are not necessarily synonymous. Prevention has three parts: (1) Primary--programs aimed at that portion of the population which is not necessarily presumed to currently have problems with alcohol but who may be prevented from ever experiencing them; (2) Secondary--programs designed to treat the problem at an earlier stage (i.e., detecting problem drinkers who are in the early stages of the disease); and (3) Tertiary--programs for treating alcoholics in the advanced stages of the disease and raising their level of functioning with a goal of total recovery. The current national target for prevention programs is to be found in primary prevention programs (i.e., programs aimed at pre-school populations

and early elementary age groups; education of parents about parenting is another example of primary prevention programming).

The education portion of this service refers to educating the community at large beginning with basic facts concerning the disease of alcoholism and its detection to the effects of alcohol on the body, drinking patterns, etc. Unlike prevention programs, education generally refers to specific information being given about alcohol or alcoholism. Prevention programs may deal with human needs, communication, etc., without becoming specific about alcohol or alcoholism but focusing on improving people's relationships as one deterrent to alcoholism.

An additional education function is to provide training and/or education to providers of services, generally professional persons involved in the delivery of care to alcoholics but not excluding mental health workers and medical personnel. Education of others such as clergy and school personnel is also appropriate to raise the level of understanding of the alcohol problem and, it is hoped, to aid in earlier detection and diagnosis.

While our solutions to the alcohol problem in Montana may need to be unique and of our own design, the needs of the alcoholic for care are rather universal. It is out of this general universality of need by people afflicted with the problem that these standards and care system have been identified. How we establish our comprehensive treatment system and who fulfills each of the functions must be our decision and our implementation.

ALCOHOL SERVICES DIVISION REGIONAL STAFF ORIENTATION

The regional staff of the Alcohol Services Division will be provided the training outlined below prior to their working within each region. The orientation is geared to help each regional staff to effectively function by themselves, although maximum supervision will be provided. In-service education to meet the needs of regional staff will be developed and conducted monthly.

- I. COMMUNICATION SKILLS DEVELOPMENT
- II. KNOWLEDGE OF ALCOHOL AND ALCOHOLISM
- III. POLICIES AND PROCEDURES
- IV. ALCOHOL SERVICE DIVISION PROGRAM
- V. DISCUSSION OF REGIONAL AREA
- VI. PRINCIPLES OF COMMUNITY ORGANIZATION
- VII. COMMUNITY EDUCATION TECHNIQUES
- VIII. PROGRAM PLANNING AND IMPLEMENTATION
- IX. EVALUATION
- X. FIELD TRIPS
- XI. PLANNING FOR FIRST MONTH'S WORK IN REGION
- XII. WRAP-UP SESSION

A P P E N D I X

E

RESUME

Robert L. Solomon, Administrator
Alcohol Services Division
Montana Department of Health and Environmental Sciences
Helena, Montana 59601
Telephone: (406) 449-3176

Born: May 30, 1933
Sharon, Pennsylvania

Marital Status: Married

Education: Public Schools, New Castle, Pennsylvania
New Castle Senior High School

1955 Pennsylvania State University, University
Park, Pennsylvania - Bachelor of Science

1959 University of California, Berkeley,
California - Master of Public Health

Work Experience:

July 1974 to present Administrator, Alcohol Services Division,
Montana Dept. of Health & Environmental
Sciences, Helena, Montana 59601

April 1970 - July 1974 Bureau Chief, Alcohol & Drug Dependence
Bureau, Montana Dept. of Health and
Environmental Sciences, Helena, Montana
59601

July 1969 - April 1970 Executive Director, Comprehensive Health
Planning Council of Spokane County, Inc.
Spokane, Washington

April 1, 1960 - July, 1969 Health Education Consultant
Montana Department of Health

RESUME

Paul H. Babbitt, Consultant
Alcohol Services Division
Montana Department of Health and Environmental Sciences
Helena, Montana 59601

Born: May 31, 1926
Kalamazoo, Michigan

Marital Status: Married
2 children - ages 9 and 16

Education:

1956 Michigan State University, East Lansing,
Michigan - Communication Arts - Bachelor
of Arts

1970 Columbia University, New York City,
Counseling Psychology and Education
Master of Arts

Additional 28 graduate credits in
Rehabilitation Counseling at the University
of Wisconsin, Madison, Wisconsin

Alcoholism Training at the National
Alcoholism Training Program for Professionals
sponsored by the Social Science Institute
Washington University, St. Louis, Missouri.

Military Experience:

May 1944 to December 1947 U. S. Navy Medical - Pharmacist's Mate
Second Class

Civil Experience:

April 1972 to present Alcoholism Program Planning and Grants
Management - Alcohol Services Division,
Montana Department of Health and
Environmental Sciences, Helena, Montana.

The previous 12 years were spent in
various rehabilitation projects. Primary
function was supervision and administra-
tion including two years of teaching
special aspects of administration at
Columbia University.

RESUME

Bill Potts
Alcohol Services Division
Department of Health and Environmental Sciences, Helena, Montana 59601

Born: December 1, 1942
Missoula, Montana

Marital Status: Married

Education:

9/62 - 6/66 University of Montana, Missoula, Montana
Bachelor of Arts

9/67 - 9/68 University of Montana, Missoula, Montana
Master of Arts
Thesis Title: The Franco-German Armistice
of June, 1940 and the German Armistice
Commission, 1940-42.
Research Area: Contemporary European
Diplomatic History.

9/70 - 1/71 Montana State University, Bozeman, Montana
Research Area: Masters Fine Art (Photography)

Military Experience:

12/68 - 7/69 U.S. Army (Regular)
82nd Airborne Division - Vietnam Campaign
Specialty - 13E20 - Artillery
Honorable Discharge

Work Experience:

8/74 to present Prevention Coordinator, Alcohol Services
Division, State Dept. of Health and
Environmental Sciences

6/73 - 8/74 Occupational Consultant, Alcohol Services
Division, State Dept. of Health & Environ-
mental Sciences

8/72 - 6/73 Health Planner & Program Coordinator
Emergency Medical Services
State Dept. of Health and Environmental
Sciences

12/71 - 8/72 Field Representative
Disease Control Division, State Dept.
of Health & Environmental Sciences

RESUME

Michael B. FitzPatrick
Alcohol Services Division
Department of Health & Environmental Sciences
Helena, Montana 59601

Born: July 5, 1944
Phoenix, Arizona

Marital Status: Married

Education:

9/62 - 6/64 Phoenix College, Phoenix, Arizona
A.A. in Liberal Arts

9/64 - 6/67 Arizona State University, Tempe, Arizona
Bachelor of Arts in Education

7/67 - 12/68 University of Minnesota, Minneapolis,
Minnesota - Master of Public Health

Military Experience:

12/68 - 10/71 U.S. Army, 1st Lt., Military Intelligence
Branch - Honorable Discharge

Work Experience:

8/74 to present Chemical Dependency
Consultant, Alcohol Services Division
Montana Dept. of Health and Environmental
Sciences, Helena, Montana

9/73 - 6/74 Visiting Assistant Professor of Health
Education, University of Oregon, College
of Health, Physical Education, and
Recreation, Eugene, Oregon

11/71 - 9/73 Health Educator, Drug Education and
Counseling For You, County of San Diego,
Health Care Agency, Oceanside, California

RESUME

Yvonne Sylva
Alcohol Services Division
Department of Health and Environmental Sciences
Helena, Montana 59601

Born: May 7, 1944
Saskatoon, Saskatchewan, Canada

Education:

9/68 - 6/71 College of Great Falls, Great Falls,
Montana - Bachelor of Science

Work Experience:

9/74 to present Program Coordinator
Alcohol Services Division
Dept. of Health & Environmental Sciences
Helena, Montana

10/73 - 9/74 Supervisor-Planner
Providence Resocialization Center
Great Falls, Montana

12/69 - 10/73 Social Services Supervisor
Follow Through Program
School District #1
Great Falls, Montana

RESUME

Norma Jean Murphy
Alcohol Services Division
Department of Health and Environmental Sciences
Helena, Montana 59601

Born: June 21, 1943
Sidney, Montana

Marital Status: Single

Education:

9/61 - 11/62	Carroll College, Helena, Montana No degree
9/63 - 12/64	Montana State University, Billings, Montana, School of Nursing, Billings Deaconess Hospital - Associate Degree in Nursing
1/68 - 3/69	Montana State University, Bozeman, Montana, Bachelor of Science in Nursing

Work Experience:

10/74 to present	Occupational Consultant Alcohol Services Division State Dept. of Health & Environmental Sciences, Helena, Montana
3/73 - 12/73	Clinic Nurse Supervisor Glasgow Air Base, Comprehensive Health Center, Glasgow Air Base, Montana
9/69 - 3/73	Community Mental Health Nurse II Eastern Montana Regional Mental Health Center, Glasgow, Montana
9/66 - 1/68	Evening Supervisor Community Memorial Hospital Sidney, Montana

CLASS SPECIFICATIONS

The new Montana Personnel Classification Plan classifies the Alcohol Services Division staff, with the exception of the Administrator, as one Public Health Educator II and four Public Health Educator III's. Included below are the classification titles and job descriptions for these positions.

PUBLIC HEALTH EDUCATOR II

Description of Work

GENERAL DUTIES: Performs professional health education duties in a specified field at local and state levels.

SUPERVISION RECEIVED: Works under general supervision of administrative superiors.

SUPERVISION EXERCISED: None

Example of Duties

Responsible for educational aspects of one or more specific programs; works with program directors in planning and executing the educational phases of particular programs, such as heart disease control, tuberculosis control, accident prevention, water pollution control, restaurant sanitation and industrial hygiene; works with school administrators and teachers in developing and improving the teaching of health and school health programs; works with teacher training institutions in developing and improving methods and courses in health teaching; writes pamphlets, prepares displays, writes radio and television scripts, prepares and presents talks to community groups; performs related work as required.

Minimum Qualifications

KNOWLEDGES: Considerable knowledge of the theories, principles and practices of public health education; modern educational philosophies and techniques; various public health programs; community organization.

SKILLS: None

ABILITIES: Ability to plan, organize and direct health education services; to establish and maintain effective working relationships with other professionals, community officials and the public; to communicate effectively both verbally and in writing.

EDUCATION: Graduation from a college or university with a Bachelor's degree in Public Health Education, Education, a behavioral science or Journalism.

EXPERIENCE: Two years of experience in a public health education field.

OR

Any equivalent combination of education and experience.

Description of Work

GENERAL DUTIES: Performs administrative and professional health education duties for area or statewide programs.

SUPERVISION RECEIVED: Works under general guidance and direction of administrative superiors.

SUPERVISION EXERCISED: Exercises supervision over program personnel as assigned.

Example of Duties

Provides direct services in health programs and some consultation in health education activities to other public health workers; assists in or is directly responsible for organizing community groups to attack a public health problem; prepares and presents health education programs to community groups, civic and service organizations in the dissemination of public health education and information; prepares specific programs to attack specified health care problems; may be assigned to such areas as health care facilities; disease control; water pollution control, or drug abuse areas; acts as liaison between community groups and the department; represents the department or the community at hearings and/or meetings; edits educational material and scientific pamphlets, manuscripts, bulletins, news releases, and radio and television scripts; prepares or supervises the preparation of original educational materials, such as pamphlets, graphs, charts, maps and displays; performs related work as required.

Minimum Qualifications

KNOWLEDGES: Considerable knowledge of the theories, principles and practices of public health education; modern educational philosophies and techniques; various and specific public health programs and community organizations.

SKILLS: None

ABILITIES: Ability to plan, organize and direct health education programs to establish and maintain effective working relationships with other professionals, community officials and the public; to communicate effectively both verbally and in writing.

EDUCATION: Graduation from a college or university with a Bachelor's degree in Public Health Education, Education, a behavioral science or Journalism.

EXPERIENCE: Three years of experience in a public health education field.

OR

Any equivalent combination of education and experience.

SECTION 7

GOALS & OBJECTIVES PROGRESS REPORT SUMMARY
OTHER ACCOMPLISHMENTS

MONTANA STATE PLAN FY 76

PROGRESS REPORT SUMMARY

Goal I Reduction of the impact on the people of Montana from alcoholism and alcohol abuse.

Goal 1.1 Establish a structure for the implementation of a de-centralized regional concept of needs assessment and definition of a plan to meet the particular needs of each region.

Current Status: Five regional plans have been developed and are contained in section 8 of this plan. The regional concept utilizing Mental Health Boards has been discontinued as of June 30, 1977. All Mental Health Boards put forth an effort to be applauded; however, for numerous reasons discussed elsewhere in this plan regionalization utilizing Mental Health Boards was discontinued.

Object 1 - To contract with each regional Mental Health Board to hire a Regional Addictive Disease Resource Development Specialist.

Current Status: Completed in July 1976.

Object 2 - To provide two (2) weeks of intensive training for the newly hired RADRDs.

Current Status: Completed in July 1976.

Object 2.1 - To provide training on a monthly basis in three day blocks during the term of RADRDS contracts.

Current Status: Objective adjusted during contract period. After January 1977 in the opinion of RADRDS and Alcohol and Drug Abuse Division staff the extent or original training needs were over estimated and no longer needed - was discontinued at this time. Prior to January 1977 objective completed as planned.

Object 3 - To have RADRDS select and identify an alcoholism resource person in each county in their region.

Current Status: Objective completed to the extent that a resource person in each of the 56 Montana counties has been identified.

The purpose of this objective was to expand and implement alcohol detoxification capability in the smaller communities and counties of Montana. To this extent the objective has not been completed. The detox capabilities in the counties is still implemented on a "hit and miss" basis.

Current Status: Slippage as mentioned above has occurred. This Objective will be implemented August, 1977.

Goal 1.1.1 Reduction of the impact on the people of Montana from alcoholism and alcohol abuse.

Objective 1 - To provide continuation funding for the RADRDS positions from termination date through 9/30/77.

Current Status:

Region I contract signed to maintain the position through 9/30/77.

Region II position discontinued July 15, 1977.

Regions III position and contract discontinued June 30, 1977.

Region IV position absorbed into Mental Health Center Alcohol Treatment Administration and funded through state treatment program contract July 1, 1977.

Objective 4 - To have each RADRDS submit a regional plan to the Alcohol and Drug Abuse Division after public hearings and meetings held on plan.

Objective 5 - To have the State Alcohol Plan reviewed by the Alcohol and Drug Advisory Council (February 15, 1977).

Current Status: Slippage has occurred on this objective due in a large part to the emphasis that was placed on passing alcohol legislation in the recent Montana Legislative session. This objective will be implemented in two steps: the first rough draft of the State Alcohol Plan will be presented to the Montana Alcohol and Drug Dependence Advisory Council June, 1977 for their review and final presentation and hopefully adoption will be August, 1977 by the Council.

Object 6 - To have the Montana State Alcohol Plan ready for public review and comment (March 1, 1977).

Current Status: Slippage has occurred in this objective due to emphasis as stated with Montana Legislature. This objective will be implemented as of July, 1977.

Object 7 - To have the State Plan FY '77 approved by HEW, Region VIII staff (April 1, 1977).

Regions V contract signed with a regional
Alcohol and Drug Corporation to maintain position
through 9/30/77.

Goal 2 Establish services for the women of Montana who are alcoholics
or abuse alcohol.

Current Status: Goal not completed, was a broad, general
non-measurable goal. No new services for women established in
FY'77. Another goal dealing with the unique problems of women
in treatment is in the FY'78 action plan.

Goal 3 Establish alcohol services specifically designed to serve
the youth of the state who are alcoholics or who abuse alcoholic
beverages.

Current Status: The program selected for a youth emphasis in
alcohol was a contract at Colstrip, Montana. This project was
picked up by private enterprise (Western Energy Corporation)
and the contract with the project was terminated as of December
8, 1976. All objectives with this particular goal have been
met due to the willingness of private enterprise to totally
fund the project and once funded in this manner, the reluctance
to have the State involved in evaluation.

Another goal dealing with the unique problems of youth and
alcohol is in the FY '78 action plan.

Goal 4 Provision of a comprehensive range of alcoholism services
for all Montana residents.

Current Status: As of June 1977 some form of alcohol treatment service available in each of the fifty-six (56) counties in Montana.

Object 1 - To provide supplementary funding for all existing alcoholism programs offering a comprehensive range of services for the residents of Montana.

Current Status: Completed June 30, 1977.

Object 2 - To provide supplementary funding for those new programs proposing to offer a comprehensive range of services for the alcoholic and alcohol abuser.

Current status: Completed June 30, 1977. Five (5) new programs were started as a result of this objective; however, of the five only one program now operates as a separate identity. The other four were started under the sponsorship of a state-approved alcohol program and are currently in various stages of development or a community program separate and independent from the sponsoring agency. In addition to establishing five new programs, five of the seven Indian reservation programs received "limited" alcohol funding for the first time.

Accomplishments of the Alcohol and Drug Abuse Division were not listed as a goal or objective in the FY'76 Montana State Plan.

1. Program Evaluation: The Montana Administrative Code mandated that each funded alcohol treatment program in the state receive an approved evaluation prior to December 1976. Twenty-six on site evaluations were completed by the required date. As a result of the mandated evaluations the need for a systematic comprehensive evaluation system became evident. By contract the evaluation system and handbook in section 5 was developed. Utilizing the new evaluation system 12 programs received technical assistance followed by an evaluation since January 1977. The new system allows both program and the state to pinpoint program weaknesses and develop strategies and time tables to correct weaknesses.
2. Montana Summer School on Alcohol Studies: The summer school was held in Great Falls at the College of Great Falls the week of June 13-17, 1977. Monday evening, June 13, 390 persons attended Father Martin's presentation; Tuesday approximately 200 persons were in attendance at the opening of the program. Many of these people did attend just to hear Father Martin; however, we also had a consistent 90+ persons in attendance during the course of the workshop. Of these 90 participants, approximately one half took the course for credit with the remainder auditing. Even with the repeaters, i.e., people attending more than once, we can safely say we impacted 500 persons directly by the school. Additionally, through media

and advertising plus word of mouth, I am sure we impacted far more than 500 persons.

The Great Falls news media gave daily coverage regarding the school. In fact, post workshop news coverage was better than the pre-workshop news coverage in terms of quantity and quality. Prior to the workshop there seemed to be a reluctance on the part of the media, to give extensive coverage.

Workshop participants were representatives of the following work areas:

Educators	20-25%
Clergy	5%
Social Workers	4-10%
Medicine.	50-70%
Citizens*.	5%

A large number of the participants are currently employed in the field of alcoholism counseling even though the workshop was billed as a beginners program. It seems as though the alcoholism professional was attracted by the curriculum and of course, by Father Martin. The others were drawn, assumedly, by the offering of education in the field of alcoholism.

*AA members, housewives, volunteers in social programs, etc.

3. Alcohol Counselor Training: During the fiscal year 12 training sessions were held with 281 alcohol counselors attending. The Alcohol and Drug Abuse Division paid the cost of the training and in many instances the per diem and travel expenses of participants.
4. Alcohol Management Information System: As a result of a contract with the Council of State and Territorial Alcohol Authorities we now have a complete MIS that meets our needs and research requirements. The new system is still in the test stages and complete implementation is not planned until November 1977.
5. Certification: State-approval of local programs implies to the general public competence on the credentialing mechanisms. Licensing, certification, and accreditation are tools which aid in assuring that the best possible conditions exist to provide quality care. Counselor certification standards have been developed through the efforts of a committee appointed by the Alcoholism Programs of Montana with their expenses paid by the Alcohol and Drug Abuse Division. The standards were developed with the attitude of including everyone now working in the field and providing all training necessary to enable every counselor in the state certification at a class II level. The Alcohol and Drug Abuse Division will provide alcohol administrators training on the intent, need, and use of counselor Class III and IV levels. During the development phase administrator's were critical of certification if they had an employee qualify as a IV when they themselves may have qualified

as a II. For this reason implementation of the certification system is planned to take place over a three year period.

6. Urban Indian Alcoholism needs identification and action plan:

During the fiscal year the division contracted with the Montana United Indian Association for the plan development. The plan developed identifies the extensive problem of alcoholism as an urban Indian problem and presents an action plan to start meeting the unique needs of this group. This plan is included as a separate state-wide regional plan.

7. Alcohol Education Movie: Through a contract with the Alcoholism

Programs of Montana a movie featuring Mr. Fess Fair has been developed for use by the television stations in Montana. This film deals with the emotional aspects of alcoholics.

8. New Residential Programs: As a result of efforts of RADRDS, interest in establishing two new residential programs has been developed. It appears that during FY'78 two new alcohol residential programs will be developed in Regions I and V.

9. Correctional Institution Counselors: Funding to employ substances abuse counselors at Pine Hills School, Swan River Youth Forest Camp, and Montana State Prison will be finalized in FY'78. Funding for these positions will come from state alcohol, formula drug and LEAA funding. These new positions are the

results of joint planning and development efforts of the Alcohol and Drug Abuse Division and Justice Department.

10. Procedure to review and fund community alcohol applications established: Alcohol Program applications for funding in FY '77 were reviewed by an Alcohol and Drug Abuse Division staff committee of three individuals reviewing and one staff member presenting and serving as a program application advocate. Summaries of this review along with the committee recommendations and program applications were forwarded to task force committees of the Montana Advisory Council on Alcohol and Drug Dependency for their review. At meetings in Helena the task force committee, with the Division application advocate, reviewed applications and made recommendations to the full Advisory Council for funding. Due to the lack of available monies a sliding percent reduction formula was applied to the Council recommendations for funding. Twenty-four grant applications were reviewed and twenty-one funded. Three applications were not funded due to the lack of available funding.
11. New alcohol funding approved: As a result of efforts of local alcohol programs, Alcoholism Programs of Montana and interested residents, Montana has made a major commitment to alcohol treatment, prevention and education. The 45th Montana Legislature increased the tax on liquor to 10% and beer to \$3 per barrel. Although only a portion of this money will directly benefit treatment, prevention and education the major commitment made by Montana should be noted. The Legislature also insured community involvement in local programs by directly funding

counties with alcohol ear marked funds.

12. Alcoholism upgraded by Department: Effective July 1, 1977

the Addictive Diseases Bureau was upgraded to division status.

The new Alcohol and Drug Abuse Division is one of four
divisions in the Department of Institutions.

SECTION 8

INTRODUCTION AND STATE SERVICE MAP AND KEY

Region I Plan

Region II Plan

Region III Plan

Region IV Plan

Region V Plan

Urban Indian Plan

INTRODUCTION

To facilitate planning and the delivery of services, the Governor has divided the state into five planning regions. These regions are the same for Health Systems Planning; Mental Health and Retardation Centers and Alcoholism and Drug Abuse Planning for services. These five regions serve as the basis for the catchment areas described in this Plan and are referred to frequently in the various sections.

In June, 1976, the Addictive Diseases Bureau implemented a regionalization concept. The five existing Mental Health Boards were asked to expand their scope from mental health to total human resources. All of the five boards agreed, and in July, 1976, five Regional Addictive Diseases Resource Development Specialists were hired by the boards to identify needs and develop regional plans. This concept has had many difficulties; and, for the most part is functioning in only three (3) regions at this time (July 1977). The regional plans for alcohol were received by the Addictive Diseases Bureau January 3, 1977. These regional plans constitute both the needs assessment and action plans for the 1977 Montana State Alcohol Plan.

The five regional plans were submitted to the Addictive Diseases Bureau in January 1977; thus, some of the material included has already become outdated. To ensure that philosophies, priorities and needs are conveyed as they were intended by each region, the state office did not edit the regional plans. All five regional plans appear in the State Alcohol Plan in their original format.

Regional Addictive Disease Resource Development Specialists

1. Ron Hjelmstad

Region I - (Carter, Custer, Daniels, Dawson,
Fallon, Garfield, McCone, Phillips, Powder
River, Prairie, Richland, Roosevelt, Rosebud,
Sheridan, Treasure, Valley and Wibaux Counties)

Plentywood, Montana
Phone 765-2530

2. * Contract terminated
3. * Contract terminated
4. * Contract not renewed for the RADRDS position, RADRDS
funded as regional alcohol service program director.

Jim Scott

Region IV - (Beaverhead, Deer Lodge, Gallatin, Granite,
Jefferson, Lewis & Clark, Madison, Meagher, Park, Powell
and Silver Bow Counties)

Alcoholism Rehabilitation Association
Suite 14-15
215 East Sixth Ave.
Helena, Montana
Phone 442-0310

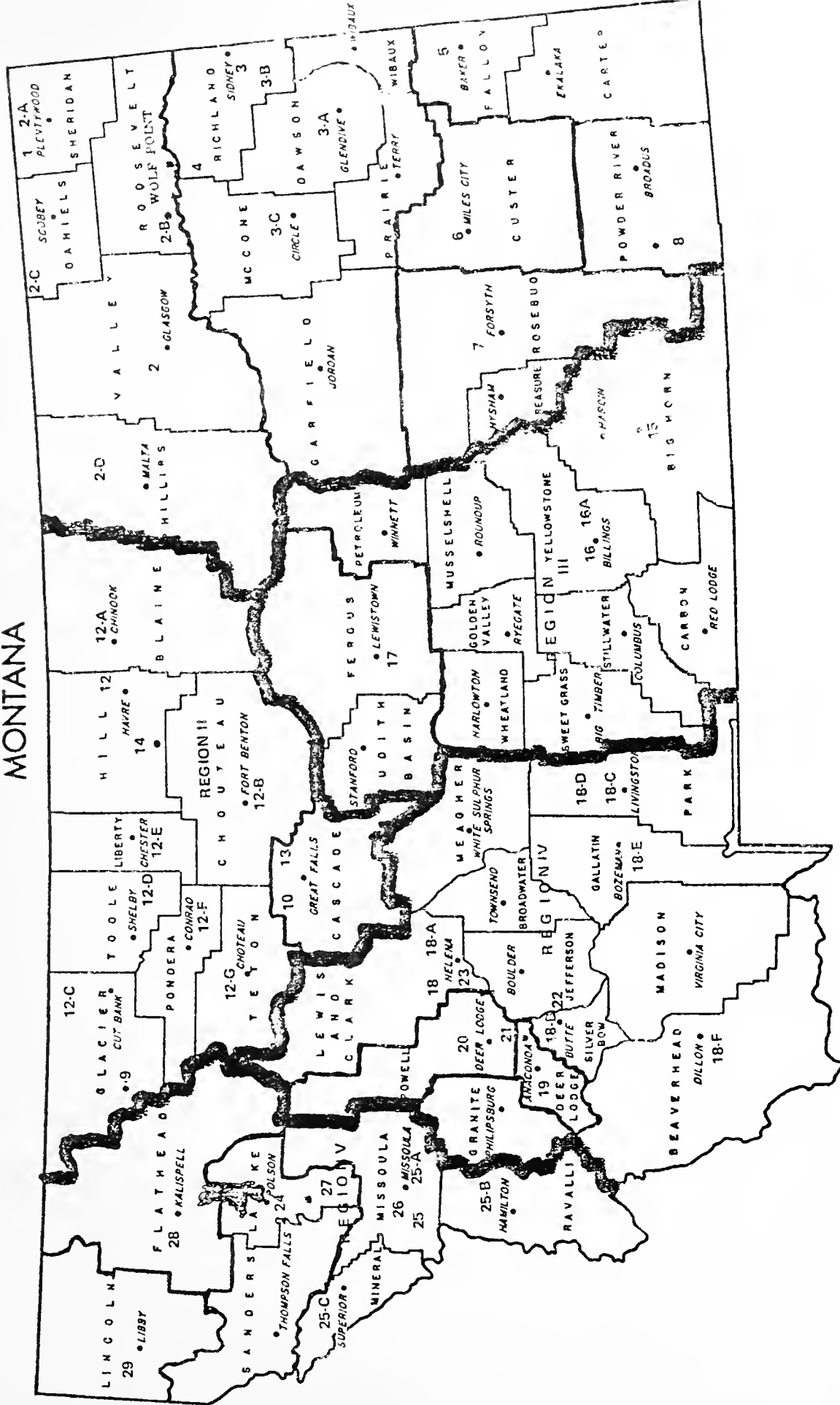
5. Ken Anderson

Region V - (Flathead, Lake, Lincoln, Mineral, Missoula,
Ravalli and Sanders Counties)
Alcohol and Drug Council

11 Third Ave. East
Polson, Montana
Phone 883-2600

NOTE: Regional organization no longer operational in
Regions 2 and 3. However, in Region 3 the Rimrock
Guidance Foundation (service provider) has assumed
a regional posture & is serving as an effective
catalyst for local alcohol Program development.

MONTANA



No. 1052 — County Outline Map
STATE PUBLISHING COMPANY
Helena



ALCOHOL PROGRAMS MAP KEY

Region I

1. RADRDS - Plentywood
2. High Plains Council for District I
 - 2-A Sheridan County
 - 2-B Roosevelt County
 - 2-C Daniels County
 - 2-D Phillips County
3. District II Public Alcoholism Program
 - 3-A Glendive Alcohol Satellite
 - 3-B Sidney Alcohol Satellite
 - 3-C Circle Alcohol Satellite
4. Fort Peck Tribal Alcoholism Program
5. Tri-County Alcoholism Program
6. Custer County Alcohol Program
7. Rosebud County Alcohol Program
8. Northern Cheyenne Reservation Alcohol Program

Region II

9. Blackfeet Tribal Alcohol Program
10. Cascade County Alcohol Program
11. Fort Belknap Tribal Alcohol Program
12. Hill-Top Recovery Center
 - 12-A Chinook Outreach
 - 12-B Fort Benton Outreach
 - 12-C Cut Bank Outreach
 - 12-D Shelby Outreach
 - 12-E Chester Outreach
 - 12-F Conrad Outreach
 - 12-G Choteau Outreach
13. Providence Resocialization Center
14. Rocky Boy Tribal Alcohol Program

Region III

15. Crow Reservation Alcohol Program
16. Rimrock Guidance Foundation
 - 16-A Alcoholism Receiving Center
17. Fergus County Alcohol Program

Region IV

18. Alcohol Rehabilitation Association of Western Montana
 - 18-A Helena Alcohol Services
 - 18-B Butte Alcohol Services
 - 18-C Park Alcohol Services
 - 18-D Steppingstone Alcohol Services
 - 18-E Bozeman Problem Drinking Center
 - 18-F Dillon Alcohol Services
19. Deer Lodge County Alcohol Program
20. Powell County Alcohol Center
21. Galen State Hospital
22. North American Indian Alliance Alcohol Services
23. Boyd's Guest House

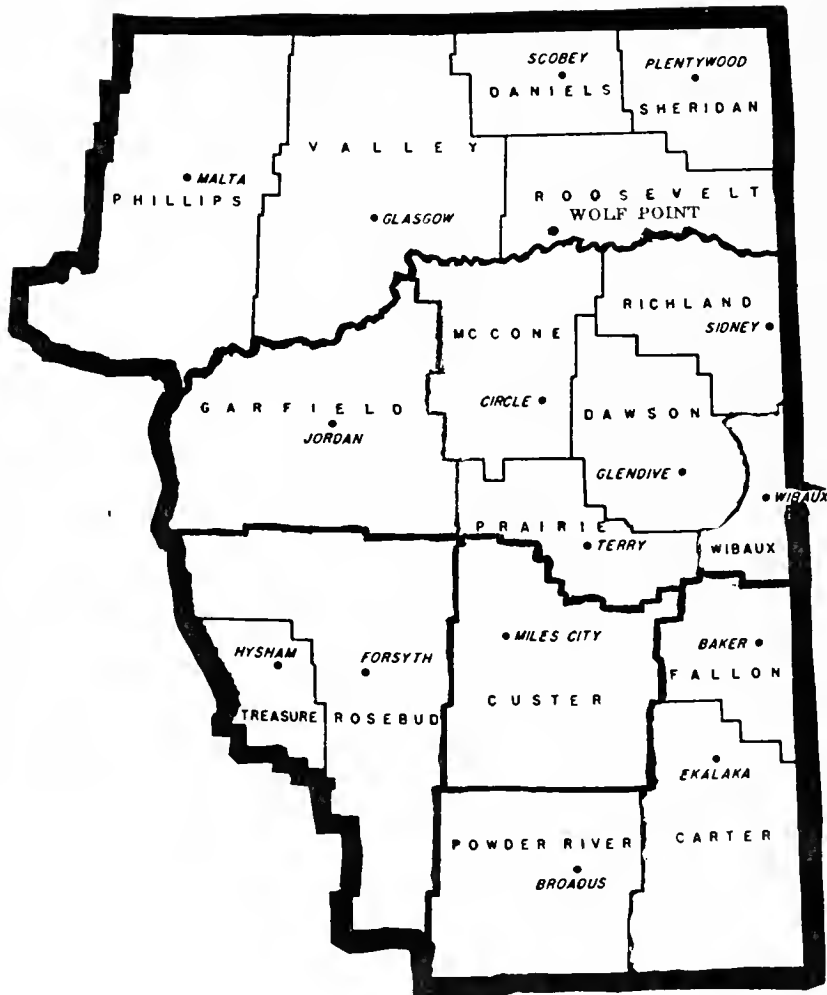
Region V

24. RADRDS
25. Alcohol Action
 - 25-A Missoula Center
 - 25-B Hamilton Center
 - 25-C Superior Center
26. Missoula Indian Alcohol and Drug
27. Flathead Alcoholism and Drug Abuse Center
28. Alcohol Service Center (Kalispell)
29. Alcohol Service Center (Lincoln County)

REGION I

ALCOHOLISM PLAN

1977-1978



GEOGRAPHIC AND DEMOGRAPHIC DESCRIPTION

The area included in this plan covers the seventeen counties which make up the Governor's planning districts 1, 2 and 3. These counties have a total population of 93,221 (1970 census) and cover a land area of 48,588 square miles. Approximately 12% of the state's total population resides in this eastern third of the state. There are 1.9 persons per square mile.

There are no towns and only four counties that have a population of 10,000 or more. Of the remaining counties, nine have populations of 5,000 or less and most of these range from one to three thousand.

Approximately 7% of the population is Indian, compared to 4.7% state-wide. There are two reservations and part of a third in the area.

Because the population is small and scattered, mainly in communities of 1,000 or less, services are also scattered and fragmented.

Eastern Montana is an area of rolling plains. The economy of the area is primarily agricultural, based on ranching and farming, plus recent coal development and some oil fields. In 1969, the average income per household in Montana was \$7,720.00, compared to the national average of \$9,220.00. In Eastern Montana, 15% of the population falls in the low income category.

Traditionally, Eastern Montana has been the land of the rugged individual, where the image of maturity includes the ability to hold one's liquor. It is an area where the heavy use of alcohol and much of the resulting behavior is socially acceptable. Thus, alcohol is still the major source of chemical abuse problems. Recently, however, other drugs have been making their presence felt. The sparseness of the population and the size of the area have slowed the spread of other chemical abuse.

Recently, coal development has started in the area. The influx of people looking for employment in the coal fields will increase the population and strain the existing health care facilities.

(17 Counties)

TOTALS	1.9 Persons Per Sq. Mi.
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REGION I ALCOHOLISM PROGRAMS

REGION I ADDICTIVE DISEASES OFFICE:

Ron Hjelmstad, Regional Addictive Diseases Resource Development Specialist
Sheridan County Courthouse
Plentywood, MT 59254
Phone: 765-2530

DISTRICT ONE ALCOHOL AND DRUG PROGRAM:

Herb Sukut, Director
Valley County Courthouse Annex
Glasgow, MT 59230
Phone: 228-9093

Jorgen Jensen
Sheridan County Courthouse
Plentywood, MT 59254
Phone: 765-2361

Gordon Cornwell
Scobey City Hall
Scobey, MT 59263
Phone: 487-5091

Barbara Taddonio
Roosevelt County Courthouse
Wolf Point, MT 59201
Phone: 653-2131

Phyllis Wimmer
Malta, MT 59538
Phone: 654-2005

DISTRICT TWO ALCOHOL AND DRUG PROGRAM:

Jack Pollari
Dawson County Courthouse
Glendive, MT 59330
Phone: 365-5942

John Brekke
Richland Co. Health
Dept.
Sidney, MT 59270
Phone: 482-4097

VACANT
Circle, MT 59215
Phone: 485-2380

CUSTER COUNTY ALCOHOL AND DRUG PROGRAM:

Jim Irvin, Director
Custer County Courthouse
Miles City, MT 59301
Phone: 232-6542

ROSEBUD CO. ALCOHOL & DRUG PROGRAM:

Bob MacConnel, Director
Forsyth, MT 59327
Phone: 356-2670

FORT PECK RESERVATION ALCOHOLISM PROGRAM:

Melvin Nagleman, Director
Poplar, MT 59255
Phone: 768-3852

COUNCIL OF COUNTIES - District I - The District One Alcohol and Drug Program is operated by the High Plains Council for District One. The Council is composed of the county commissioners and the mayors of all incorporated cities in Sheridan, Daniels, Phillips, Roosevelt, and Valley Counties. An eight-man elected Executive Board is the governing board for the alcoholism program. The program maintains offices in each of the five county seats of the District. Staffing of these offices is as follows:

Glasgow - Herb Sukut, Program Director and a counselor
for Valley Co.
Malta - Phyllis Wimmer, Counselor for Phillips County
Wolf Point - Barbara Taddonio, Counselor for Phillips County
Scobey - Gordon Cornwell, Counselor for Daniels County
Plentywood - Jorgen Jensen, Counselor for Sheridan County

The program provides out-patient, out-reach and referral, consultation and community education to the citizens of District One. Emergency medical services are provided by local hospitals and physicians in the area. The program is supported by \$54,783.69 from ADB and local matching funds.

COUNCIL OF COUNTIES - District II - The District Two Alcohol and Drug Program provides services to Dawson, Richland, McCone and Garfield Counties. Two counties, Wibaux and Prairie, in the District are not participating in the program at this time. (See Objective 1.2 and Objective 1.3). The Governing Board of the program is the Richland County Commissioners. The program maintains offices in Glendive, Sidney and Circle. Staffing of these offices is:

Sidney - John Brekke, Counselor for Richland County
Glendive - Jack Pollari, Counselor for Dawson County
Circle - Vacant, Counselor for McCone & Garfield Counties

The program provides out-patient, outreach and referral, consultation and community education services. Emergency medical services are provided

by local hospitals and physicians. The program is supported by \$30,000 from ADB and local matching funds.

FORT PECK RESERVATION ALCOHOLISM PROGRAM - This program serves the reservation population through its offices in Poplar. The governing board of the program is the Fort Peck Tribal Council, Norman Hollow, Chairman. Melvin Eagleman is the Program Director. Services provided include de-tox, intermediate care, out-patient, out-reach, prevention and education and a specialized youth program. Major sources of funding are IHS and NIAAA. The youth program is supported by \$10,019.34 from ADB and tribal matching funds.

CUSTER COUNTY ALCOHOL AND DRUG PROGRAM - This program is operated by the Custer County Commissioners and is governed by the Phoenix Corporation, an Advisory Board chosen by the County Commissioners. The program offers out-patient, out-reach and referral, consultation and community education services through its office in Miles City. Jim Irvin is the Program Director and County Counselor. Emergency medical services are provided by Holy Rosary Hospital in Miles City and local physicians. The program is supported by \$11,702 from ADB and local matching funds.

NORTHERN CHEYENNE ALCOHOLISM PROGRAM - This program has requested that they be included in Region III. See Regional plan for that area.

ROSEBUD COUNTY ALCOHOL AND DRUG PROGRAM - This program is operated by the Rosebud County Commissioners. The program offers out-patient, out-reach and referral, consultation and community education services through its office in Forsyth. Bob MacConnel is Program Director and

County Counselor. Emergency medical services are provided by the Rosebud Community Hospital and local physicians. The program is supported by \$9,633 from ADB and local matching funds.

FY-76 FUNDING FOR EXISTING ALCOHOLISM PROGRAMS IN
REGION I AND ESTIMATED INCREASES FOR FY-77

	ADB	LOCAL	TOTAL FY-76	EST. FY-77 INCREASE	EST. FY-77 TOTAL
Rosebud County	9,633.33	4,816.67	14,450.00	4,000.00	18,450.00
District II	30,000.00	15,000.00	45,000.00	26,000.00	71,000.00
District I	54,783.69	27,391.85	82,175.54	7,824.46	90,000.00
Custer County	11,702.00	5,851.00	17,553.00	15,000.00	32,553.00
Fort Peck Youth	10,019.34	5,009.67	15,029.01	12,000.00	27,029.01
TOTALS	116,138.36	58,069.19	174,207.55	64,824.46	239,032.01

\$33,000 of the projected increased budgets for existing programs are included in the goals and objectives of this plan.

The remaining \$31,824.46 will:

...Return the District I program to a full-time staff of one Director and five Counselors.

...Provide a salaried program coordinator for the District Two Alcohol and Drug Program.

...Provide one additional staff member to the Fort Peck Youth Program.

...Provide normal salary increases for permanent staff of existing programs.

REGION I

PROBLEM #1:

Areas of Eastern Montana do not have identifiable and accessible community based alcoholism programs.

Goal #1:

To encourage and assist in the creation of community based alcoholism programs in the counties of Eastern Montana where none exist. Specifically, the counties of Prairie, Wibaux, Fallon, Carter, Powder River and Treasure.

It is planned that by January 1, 1977 a portion of the \$190,000 Uniform Alcoholism Act Federal Incentive Grant (\$37,000 in Region I) will be used to create three new staff positions which will provide direct services, outreach and resource development, and prevention and education services to these 6 counties, as well as provide an additional half-time counselor each for Miles City and Glendive for the five month period from January 1 to June 30, 1977. Estimated cost - \$25,000.00. The intent of providing these services to these Eastern Montana counties is to demonstrate the need for and the effectiveness of community based alcoholism services to the government and the citizens of those counties.

Objective 1.1:

By April 1, 1977, as a result of providing community based services, to have developed local support that will provide the required matching¹ funds to acquire State Addictive Diseases Bureau funding for a permanent alcoholism program.

Objective 1.2:

By April 30, 1977 - to have the required proposal and documentation prepared, submitted and approved by the Addictive Diseases Bureau to create a new community based alcoholism program, providing services to Wibaux, Fallon, and Carter Counties.

Total population	7,471
Total estimated alcohol abusers (8.5%)	635
Total others affected (635 x 6)	3,810
Total potential consumers of direct services	4,445

Cost - \$16,500 (\$5,500 local match, \$11,000 state ADB funds)

Objective 1.3:

By April 30, 1977 - to have the required proposal and documentation prepared, submitted and approved by the Addictive Diseases Bureau

¹ This requirement was removed by legislative action.

that will add one full-time counselor to the District II program in Glendive. This counselor will divide his/her time between Glendive, (Dawson County) and Terry (Prairie County). At the present time, Glendive (Dawson County) has one full-time counselor attempting to provide services to a total population of 11,269. Additional staff is required. Prairie County does not receive services at this time.

Total population	13,021
Total estimated alcohol abusers (8.5%)	1,107
Total others affected (1,107 x 6)	6,642
Total potential consumers of direct services	7,749

Cost - \$15,000 (\$5,000 local match, \$10,000 State ADB funds).

Objective 1.4:

By April 30, 1977 - to have the required proposal and documentation prepared, submitted and approved by the Addictive Diseases Bureau that will add one full time counselor to the Custer County Alcohol Program in Miles City. This counselor will divide his/her time between Miles City and Broadus (Powder River County). At the present time, Miles City has one full-time counselor attempting to provide services to a total population of 12,174. Additional staff is required. Powder River County does not receive services at this time.

Total Population	15,036
Total estimated alcohol abusers (8.5%)	1,278
Total others affected (1278 x 6)	7,668
Total potential consumers of direct Services	8,946

Cost - \$15,000 (\$5,000 local match, \$10,000 State ADB funds).

Objective 1.5:

On April 30, 1977 - to have the required proposal and documentation prepared, submitted and approved by the Addictive Diseases Bureau that will enlarge the area covered by the Rosebud County Alcoholism Program to include services to Treasure County (Hysham) on a part-time basis. No additional staff will be required.

Cost - \$3,000 (\$1,000 local, \$2,000 ADB).

Eastern Montana does not have in-patient alcoholism treatment facilities which are readily accessible. The Montana Alcoholism Services Center at Galen is 350 miles from the Western counties of the Region and well over 500 miles from the eastern counties.

Because of these distances, many alcoholics must utilize out-of-state inpatient facilities for treatment. However, most out-of-state facilities are quite often full with residents from their own area. It is not unusual for an alcoholic needing in-patient treatment to be placed on a waiting list in order to enter a Center.

All the recent data on successful treatment of alcoholism suggests that the family of the alcoholic must be involved in the recovery program. This family involvement insures the best chance of recovery. The lack of nearby facilities prohibit most of the families of alcoholics in Eastern Montana from taking part in the in-patient treatment program. Community based programs attempt to provide counseling and education services to the family members during the alcoholic's stay in residential treatment, however, distance again severely hampers the coordination of effort between community program and residential treatment facilities.

Eastern Montana must have better access to in-patient treatment facilities in order to develop more effective rehabilitation services for alcoholism.

Goal #2:

To encourage and assist in the creation of adequate in-patient alcoholism treatment facilities in Eastern Montana.

Two general hospitals in Eastern Montana, Holy Rosary of Miles City and Frances Mahon Deaconess of Glasgow, have expressed interest in increasing the scope of services to include an alcoholism treatment unit (ATU). Holy Rosary Hospital proposes to convert one floor of their existing facility to house an A.T.U. Frances Mahon Deaconess has a new wing under construction at this time and proposes to use one floor of the vacated present facility to house an A.T.U.

Based on information from existing out-of-state in-patient facilities, the Montana Alcoholism Services Center at Galen, and Region One Alcoholism Programs, it is estimated that 200 to 250 patients would utilize these facilities during the first 12 months of operation.

Both projects will require some degree of remodeling to provide sufficient facilities to effectively operate an A.T.U. Both hospitals lack the funds to absorb the initial costs of hiring specialized staff, increasing staff and purchasing needed materials (books, films, etc.) needed to create A.T.U.'s.

It has been projected that in FY 77 the Dept. of Institutions will make \$150,000 available to Region I for the purpose of providing in-patient alcoholism treatment for the citizens of Eastern Montana.

The availability of these funds would effectively subsidize the initial costs of creating A.T.U.'s in these Eastern Montana hospitals until they become self-supporting.

Objective #2.1:

Between July 1, 1977 and Sept. 1. 1977 - to have developed contracts with Holy Rosary Hospital of Miles City and Frances Mahon Deaconess Hospital of Glasgow to provide each facility with a subsidy of \$50,000 to be used to create A.T.U.'s.

Cost - \$100,000 (Dept. of Institutions \$150,000 regional grant).

Objective #2.2:

For the period of FY 77, July 1-June 30, 1978, to contract with existing in-patient alcoholism treatment facilities to provide needed in-patient treatment for those alcoholics of Region I who cannot pay for treatment on their own. Maximum per each contract - \$1,250, to pay for all services, including medical, housing, food and alcoholism treatment.

Cost - \$50,000 (Dept. of Institutions \$150,000 regional grant).

Objective #2.3:

To begin on July 1, 1977 - to work with Holy Rosary Hospital of Miles City and Frances Mahon Deaconess Hospital of Glasgow to provide assistance in planning, developing and implementing all aspects of the proposed A.T.U.'s. To assist in selection of treatment modality, selection of staff, information of treatment program, and development of effective communications and working agreements with community based alcoholism programs, other hospitals and physicians, all human service agencies and business and industry throughout Region I.

Cost - None, included in RADRDs contract.

Objective #2.4:

To have both in-patient alcoholism treatment facilities operational by December 1, 1977.

Cost - None.

Because of the size of Region I (48,588 sq. miles) and the low density of population (93,221 - total - 1.9 persons per sq. mile), community based alcoholism programs are necessarily scattered and a considerable distance from each other. Individual counselors have large areas to cover with numerous small communities in each area. The effort to coordinate and deliver effective prevention and public education services is severely hampered by these factors. It is not unusual for a counselor to be forced to slight one area of service (counseling, out-reach, prevention and education, etc.) in order to maintain more efficiency effectiveness in another. In most cases, when the demand for direct services increases, the provision of prevention and public education decreases.

A second difficulty is that, again because of the distance and time factor, it is very difficult for staff members to work together on prevention and education projects. Obtaining input and collaboration from other skilled counselors is difficult. Consequently, prevention and education services throughout the Region lack the quality, intensity, coordination and standardization that is so vital to this priority area.

Goal #3:

To create three new alcoholism staff positions in Region I for the purpose of developing, coordinating, implementing and assisting in the delivery of prevention and education services. The position, (prevention and education coordinator) will require knowledge and skill in developing curriculum for specific target groups at the community level, i.e. teachers, students, law enforcement, medical personnel, as well as programs designed to reach the general population.

The prevention and education coordinator must have a high degree of knowledge in all areas of alcohol and drug abuse.

The coordinator's duties will be to supervise all aspects of prevention and education in the Region (Governor's planning districts 1,2 and 3).

He will be responsible to the program director and the governing board of each district.

Objective #3.1:

July 1, 1977 - to include a distinct prevention and education coordinator as staff in each of the three districts within Region I.

Cost - \$42,000 (\$36,000 from FY 77 Uniform Alcoholism Act Incentive Grant, \$6,000 included in the FY 77 RADRD funds.

Objective #3.2:

April 1, 1978 - to have developed a region-wide system of prevention and education programs that are of a quality that will allow alternate sources of funding to be utilized. Such as contracts for services with school districts, hospitals, and other community based human service agencies. These contracted services will then provide a portion of the matching funds required to obtain ADB funds for FY 78, that will continue the three positions of District Prevention and Education Coordinator.

PROBLEM #4:

Senior citizens (age 65 and older) have been ignored as a specific target population with problems resulting from alcohol abuse and alcoholism.

In June, 1976, the following data on alcohol and the elderly, by the National Clearinghouse for Alcohol Information was published.

...The elderly represent an increasing proportion of our population. In 1920, less than 5 per cent of the nation's population was 65 years of age or older. In 1976, that proportion exceeds 10 per cent, totaling approximately 22 million citizens.

...Of the approximately 22 million Americans over 65, as many as 1.6 million may be alcoholic.

...A careful review of hospitalization statistics shows some indication that the proportion of older alcoholics is significant.

...The aged who have drinking problems are likely to have health conditions that complicate their situation. They are apt to face economic problems, difficulties associated with disengagement from the labor force and similar social relationships, bereavement, and other concerns that require considerable social and psychological adjustment.

...An older person with a drinking problem faces two sets of related problems: the one resulting from old age and the other from alcoholic abuse. Indeed, these problems may have a synergistic quality with the result exceeding the sum of the parts.

...One study found that older problem drinkers appeared to suffer from significant isolation, loneliness, and other psychological pain. The most important reasons for drinking were found to be those associated with coping and escape.

...Community facilities are in short supply, there is an insufficient body of manpower and a lack of treatment know-how for problems specific to the elderly. Compounding the problem is a lack of personal resources or insurance benefits sufficient to secure available services to the aged. Frequently, the problems and needs of these persons have been ignored by both service agencies and social analysts.

...The older problem drinker may not interact with many other persons, in a job, or a social situation. The usual means whereby a younger drinker is identified - work impairment, a driving arrest, or a family referral - are less common among the elderly and treatment will be deferred.

...Older, retired problem drinkers are often regarded as poor treatment risks. Agencies may feel, consciously or not, that resources are better spent on younger problem drinkers for whom rehabilitation may be identified by a return to employment.

Eastern Montana has a population of 9,856 persons age 65 or older. As many as 840 of these senior citizens may be alcoholic, with an additional 5,040 people possibly affected. There are 5,880 residents of Eastern Montana who are potential consumers of alcoholism services as the result of alcoholism among senior citizens.

²It has not been demonstrated that ripple effect of 6:1 for elderly is correct ratio.

Goal #4:

During FY 77, to develop a region-wide effort to identify the needs and provide the services peculiar to alcoholism among senior citizens. The result of this effort will be the creation of specific working relationships with senior citizens programs and alcoholism programs throughout Region I, which will eventually reduce the impact of alcoholism upon the elderly.

Objective #4.1:

By Sept. 30, 1977 - to have a series of three workshops, one in each district of Region I, to identify the specific needs of senior citizens afflicted with or affected by alcoholism.

Objective #4.2:

By December 1, 1977 - to have developed a specific plan to provide specialized services for senior citizens.

Objective #4.3:

By February 1, 1978 - to fully implement a senior citizen's alcoholism project in Region I.

Cost - included in RADRDS FY 77 funds.

PROBLEM #5:

Region I has a population of 93,221, of which 46,365 (49%) are female.

Females over 18 years of age number 28,610 (30.69% of total).

In a NIAAA publication, women were identified as the fastest growing group of problem drinkers seen in recent years.

Estimates place the number of female alcoholics in the nation at three million increasing. We estimate that there are approximately 2,500 female alcoholics in Region I.

We believe that the stigma which surrounds the alcoholic is compounded when the alcoholic is a female.

For most of our nation's history, it has been considered "un-lady-like" to be drunk or, in some cases, to drink at all. The exact opposite of our standards for male drinkers, where heavy drinking is a measure of manhood and drunkenness is socially acceptable.

It is not too long ago that "unescorted ladies" were not welcome in public bars and taverns. Women who frequented bars were assumed to be of low moral character.

While the practice of women drinking in public has changed, much of the old moralistic attitudes remain. This moralizing is sometimes strongest among women themselves. It contributes to the reluctance among women to identify drinking problems and seek appropriate treatment.

Goal #5:

To take the necessary steps throughout Region I to begin to reduce the critical public attitude that is preventing the female alcoholic from seeking proper treatment.

Objective #5.1:

By October, 1977 - for local alcoholism programs and the RADRDs to have met with 75% of the women's organizations in the communities of Region I.

Objective #5.2:

By Dec. 1, 1977 - through the assistance of these women's organizations, have held three workshops on female alcoholism, one in each district of Region I. The purpose of these workshops will be to identify specific problem areas of the female alcoholic in Region I and develop a plan to provide specific services to deal with female alcoholism.

Objective #5.3:

By February 1, 1978 - have the specialized plan implemented with all alcoholism programs throughout Region I.

Cost to implement - included in FY 77 RADRDs contract.

³Alcohol, Health and Research World, Summer 1974

Goal #6:

To encourage, assist and support in every way possible, the development of improved relationships between all alcoholism service providers throughout the Region; to encourage the Fort Peck Alcoholism Program to take an active part in the overall planning for Region I; to assist in any way possible the continued and increased funding of the Fort Peck Program to insure that comprehensive services are made available to their residents.

Cost - included in FY 77 RADRD funds.

PROBLEM #7:

Eastern Montana has vast amount of unmined coal which are already being counted upon to become part of the solution to this nation's energy crisis.

The Western Governor's Regional energy Policy Office in Denver, Colorado has stated that it is not a question of if Eastern Montana's coal being mined, it is only a question of when it will be mined. Eastern Montana should be preparing now for the inevitable impact upon our citizens and communities.

The much publicized problems of Rosebud County and the surrounding area, resulting from the Colstrip project, should serve as a reminder for the rest of Eastern Montana to take whatever actions are necessary to insure that the economic benefits of coal and other mineral development is not overshadowed by the impact of social problems and their consequences.

As the industrial developments take place throughout Eastern Montana there will be an increase in population, more people will consume more alcohol, more alcohol consumption will inevitably result in more alcohol related problems and more cases of alcoholism.

Eastern Montana must begin at once to prepare for the alcohol and other chemical abuse problems that lie ahead. Waiting until these problems come upon us will be disastrous. We must have the complete network of community based services in place and functioning before the crisis occurs.

Alcohol and drug abuse programs will be only one part of the needed preparation, law enforcement, hospitals, doctors, social services, schools, housing and recreational facilities will all be affected. However, effective alcohol and drug programs will be an absolute necessity to the overall planning for the social impact in Eastern Montana.

Goal #7.1:

To use the goals and objectives of creating new out-patient programs, increasing staff of existing programs, creation of in-patient treatment facilities and the developing of human resources outlined in this plan as the initial steps in preparing for the social impact of economic development in Eastern Montana.

Goal #7.2:

During FY 77 - to utilize the offices and personnel of:

1. The Addictive Diseases Bureau
2. The Regional Human Resources Board
3. The RADRDS
4. The community based alcoholism programs
5. Eastern Montana county and city government,

to secure needed additional funding from the monies generated by the 30% Montana coal tax established by Senate Bill 87. This additional funding will insure that alcohol and drug abuse service programs can be developed throughout Eastern Montana that will meet the required need.

Cost - included in FY 77 RADRDS funds.

COST TO IMPLEMENT PLAN

Total projected costs for existing alcoholism programs in Region I for FY 77	239,031.67	49.6%
Estimated cost of administration and RADRS	40,000.00	8.3%
Goal #1 - NEW COMMUNITY BASED PROGRAMS IN WIBAUX, FALLON & CARTER COUNTIES, & NEW STAFF FOR DISTRICT TWO ALCOHOL & DRUG PROGRAM & CUSTER COUNTY ALCOHOL AND DRUG PROGRAM		
Objective #1.2 - New Program in Wibaux, Fallon & Carter County	16,500.00	3.4%
Objective #1.3 - included in District Two FY 77 program		
Objective #1.4 - included in Custer County FY 77 program		
Objective #1.5 - included in Rosebud County FY 77 program		
Goal #2 - IN-PATIENT FACILITIES		
Objective #2.1 - hospital subsidy	100,000.00	20.8%
Objective #2.2 - contracts for services	50,000.00	10.4%
Objective #2.3 - included in RADRS FY 77 funds		
Objective #2.4 - included in Obj.'s #2.; & #2.2		
Goal #3 - PREVENTION AND EDUCATION COORDINATORS		
Objective #4.1 - \$6,000 included in FY 77 RADRS funds	36,000.00	7.5%
Objective #4.2 - included in Obj. #4.1		
Goal #4 - SERVICES FOR ELDERLY ALCOHOLICS		
Objectives #4.1, 4.2 and 4.3 - included in FY 77 RADRS funds		
Goal #5 - SERVICES FOR FEMALE ALCOHOLICS		
Objectives #5.1, 5.2 and 5.3 - included in FY 77 RADRS funds		
Goal #6 - INDIAN ALCOHOLICS - included in FY 77 RADRS & program funds.		
Goal #7 - ECONOMIC DEVELOPMENT - included in FY 77 RADRS & program funds.		
TOTAL COST TO IMPLEMENT FY 77 REGION I PLAN	\$481,531.67	100.00%

EVALUATION AND STANDARDS

For the most part, the goals and objectives presented in this regional plan will result in increasingly recognizable elements of alcoholism services throughout Region I.

PHASE I:

At the outset, the primary responsibility for initiating the FY 77 plan will be with the RADRDS for Region I:

Ron Hjelmstad
Region I Addictive Diseases Office
Sheridan County Courthouse
Plentywood, MT 59254
Office Phone (765-2530); Home Phone (765-2888)

The responsibility of evaluating progress toward implementation during the initial stages will be with the State Addictive Diseases Bureau and the Region I Human Resources Board.

PHASE II:

When the planning and development stages of implementation are completed, a portion of the responsibility for carrying out this plan will be with the alcoholism programs throughout Region I.

The responsibility of evaluation during this phase of implementation will be with the Addictive Diseases Bureau, the Region I Human Resources Board and the alcoholism program governing boards throughout Region I.

PHASE III:

After the goals and objectives of this plan have been fully implemented, it will be the responsibility of the alcoholism programs and their personnel throughout Region I to incorporate these services into their delivery of services system on a permanent basis.

Responsibility for evaluation of these services will be with the Addictive Diseases Bureau, the Region I Human Resources Board, the RADRDS, Alcoholism Program Directors and their individual program governing boards.

The Addictive Diseases Bureau has adopted a uniform evaluation system for alcoholism programs in which the programs must meet specific requirements in the components of administration, record keeping, reporting and delivery of services. Alcoholism programs throughout the State of Montana must meet these minimum requirements in order to be approved for state funding. In addition, the Addictive Diseases Bureau is undertaking a program of individual counselor certification and is also developing an in-state alcoholism counselor training program.

The systematic transfer of responsibility to include all levels of alcoholism service providers within Region One offers the best opportunity for full implementation of this plan. It will institute a system of continuing evaluation throughout FY 77.

		1977												1978					
		Jan.	Feb.	Mar.	Apr.	May	Jun	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
GOAL No. 1																			
OBJECTIVE 1.1				X															
OBJECTIVE 1.2		X		X															
OBJECTIVE 1.3		X		X															
OBJECTIVE 1.4		X		X															
OBJECTIVE 1.5		X		X															
GOAL No. 2																			
OBJECTIVE 2.1							X	X		X									
OBJECTIVE 2.2							X	X		X									
OBJECTIVE 2.3							X	X		X									
OBJECTIVE 2.4							X	X		X									
GOAL No. 3																			
OBJECTIVE 3.1		X					X	X											
OBJECTIVE 3.2							X	X								X	X		
GOAL No. 4																			
OBJECTIVE 4.1		X								X	X								
OBJECTIVE 4.2										X	X								
OBJECTIVE 4.3										X	X				X	X			
GOAL No. 5																			
OBJECTIVE 5.1										X	X								
OBJECTIVE 5.2																			
OBJECTIVE 5.3															X	X			
GOAL No. 6		X																	
GOAL No. 7.1								X											
GOAL No. 7.2								X											

The total economic loss to our society from the problems of chemical dependency is counted in billions of dollars.

The cost of developing methods to deal with those problems is high.

The regional concept of delivering alcohol and drug abuse services requires local funds as well as local concern and action.

We feel that the citizens of Eastern Montana have demonstrated their recognition of the need for alcohol and drug abuse services by their financial support of the existing programs, whenever possible.

At the present time, state ADB funds require a 1/3 local match. This match must be cash. No soft match or in-kind contributions are acceptable. This requirement places a sparsely populated county in the position where they may not be able to afford participation in an alcoholism and drug abuse program.

The sale of alcoholic beverages contributes large sums of money to the State General Fund. We recognize and appreciate the fact that the Montana State Legislature has been supportive of chemical dependency programs. We also feel that the magnitude of the problem dictates what we take decisive and progressive steps today, in order to meet the challenge of the future.

We feel that increased allocations of these funds to support alcoholism programs would be beneficial to all citizens of Montana.

We encourage the State of Montana to consider the following issues during FY 77:

-
- 4...Substantially increased allocations of funds for the support of chemical dependency service programs.
 - 5...Changing the alcoholism program matching requirements from the present 1/3 local, 2/3 state - to - 20% local, 20% state, with 25% if the local requirement allowed to be in-kind match.
 - ...To make it mandatory for health insurance companies doing business in Montana to include coverage for alcoholism treatment.

Taking these steps would greatly enhance the movement toward a truly comprehensive state-wide system of services for chemical dependency problems.

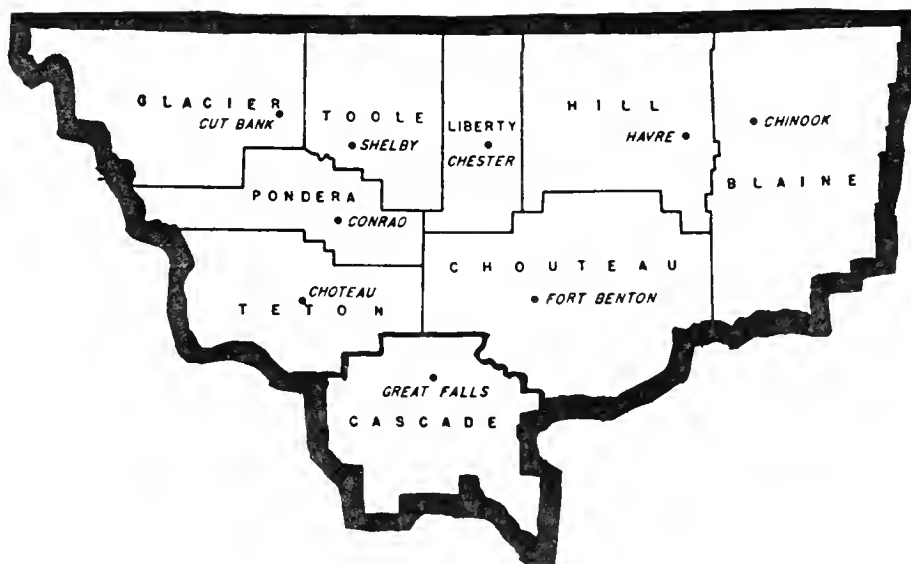
⁴ Increased by legislative action in 1977 session.

⁵ Changed by legislative action in 1977 session.

REGION II

ALCOHOLISM PLAN

1977-1978



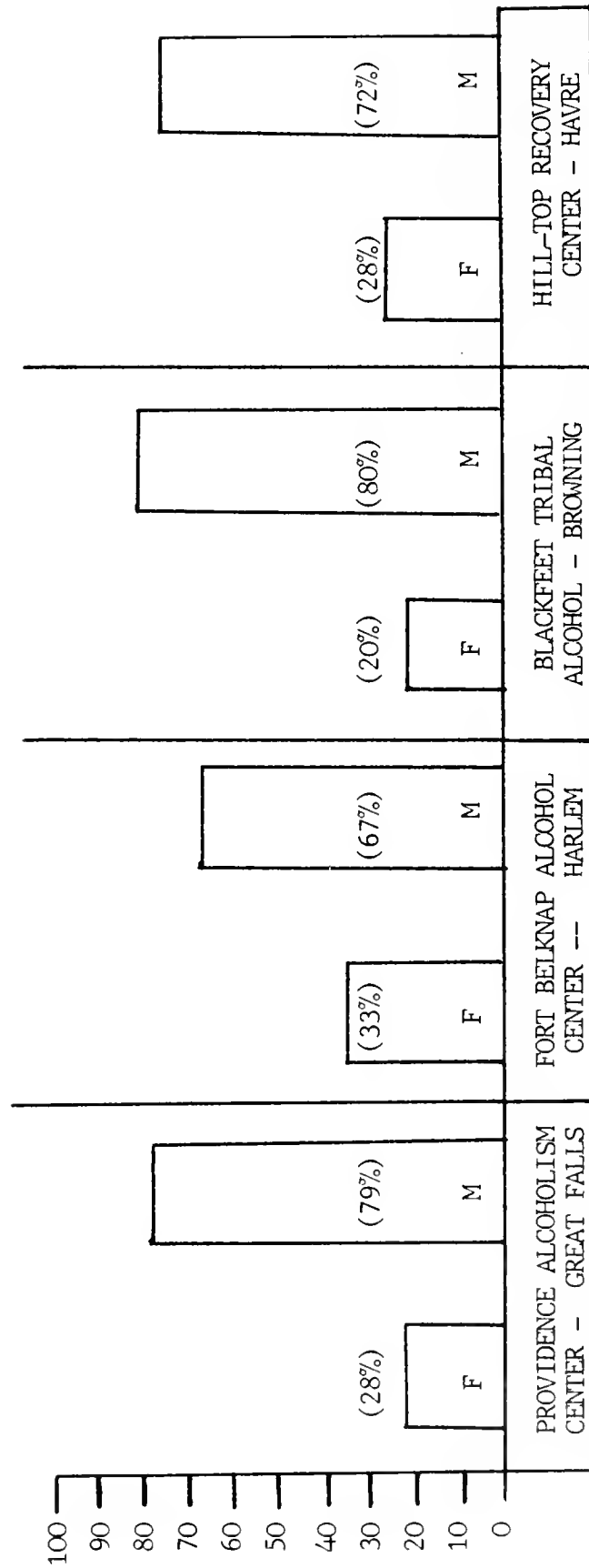
Region II Analysis of Statistics

The following seven pages identify component data pertinent to Alcoholism in Region II. These statistics are for a three month period. On July 1, 1976, the Addictive Diseases Bureau - Helena, incorporated this form of data collecting into their system, and it has been accepted and found workable by the Alcoholism Service Providers in Region II.

A healthy indication can be found on the last page of the report titled "Total for Region II." Service provider time for direct and indirect service to clients was 66% (49% direct, 17% indirect). Administrative time was 34% planning and operations.

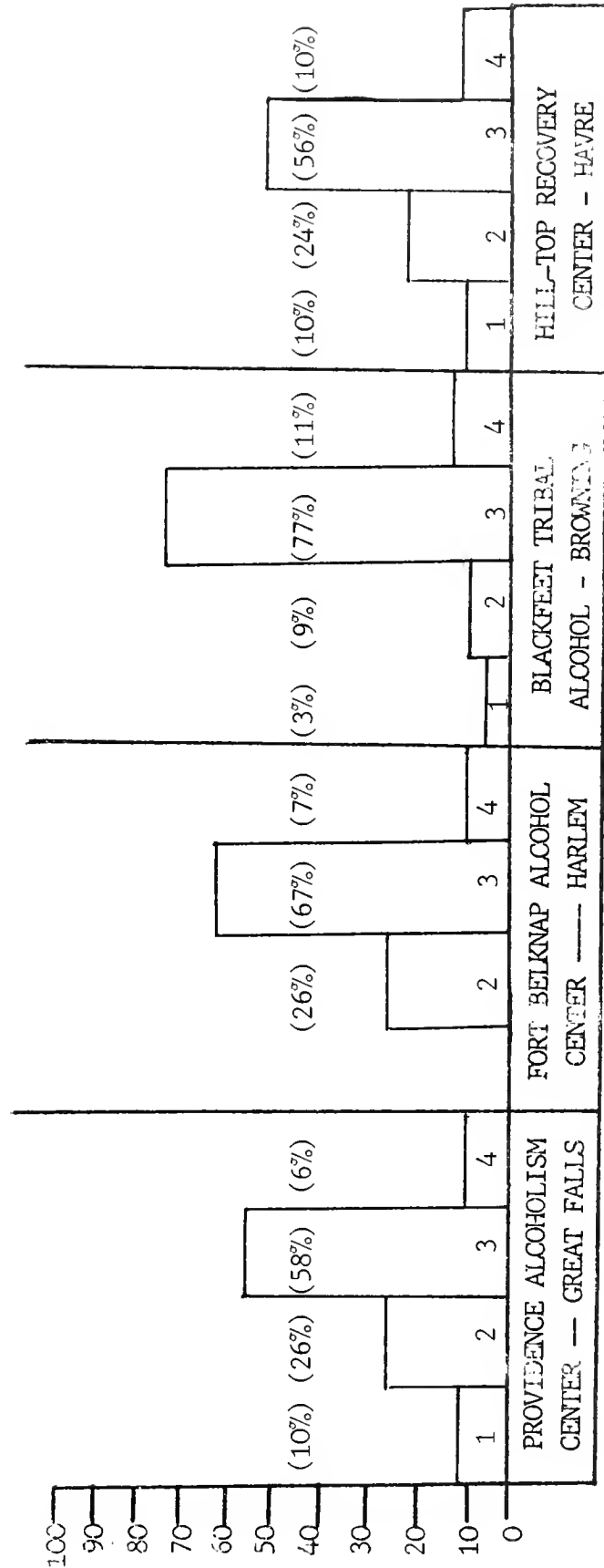
REGION II
ANALYSIS OF SEX
JULY - SEPTEMBER 1976

F = Female
M = Male



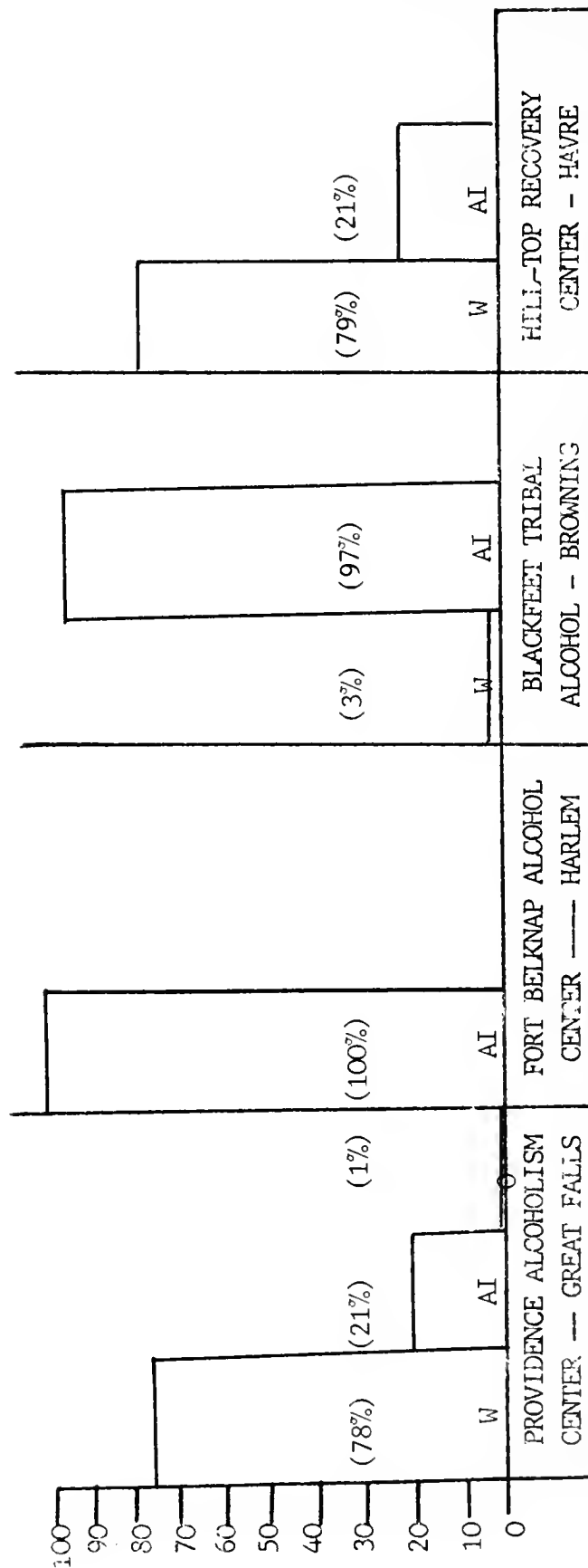
REGION II
ANALYSIS OF AGE
JULY - SEPTEMBER 1976

1 = 10-20 Yrs.
2 = 21-30 Yrs.
3 = 31-60 Yrs.
4 = 61 + Yrs.



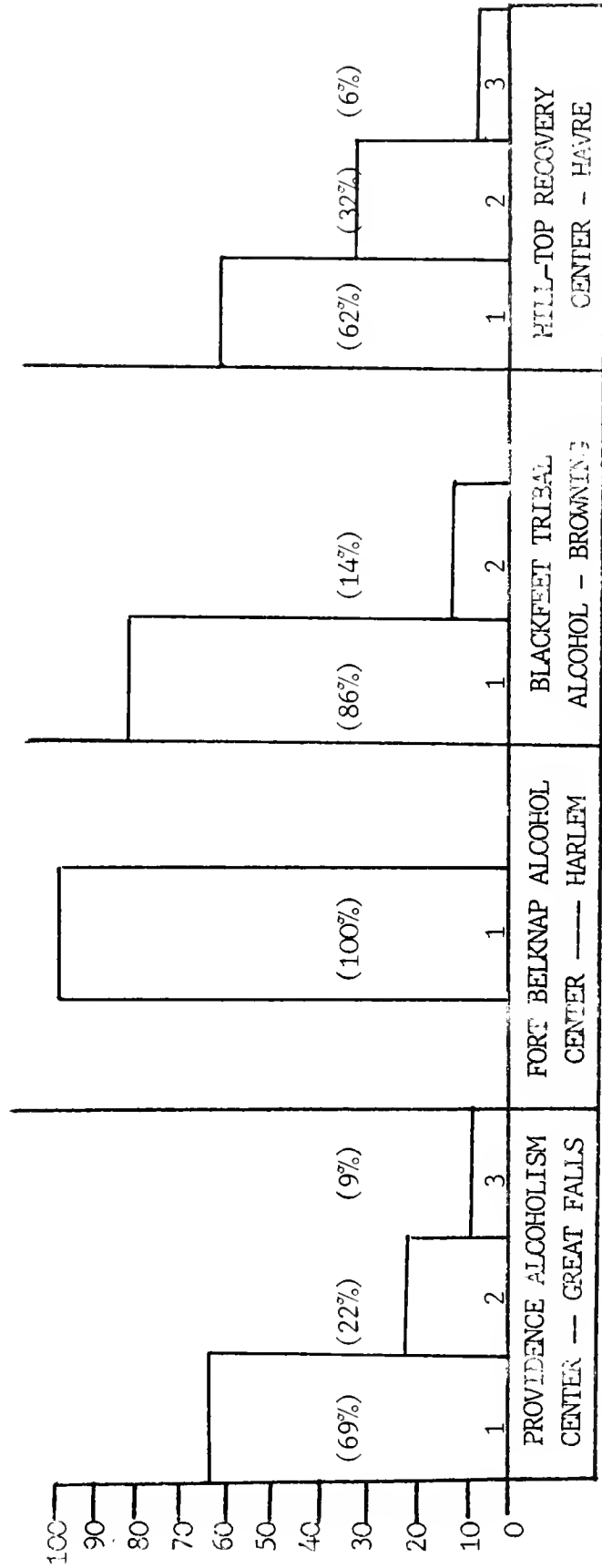
REGION II
ANALYSIS OF RACE
JULY - SEPTEMBER 1976

W = White
AI = American Indian
O = Other



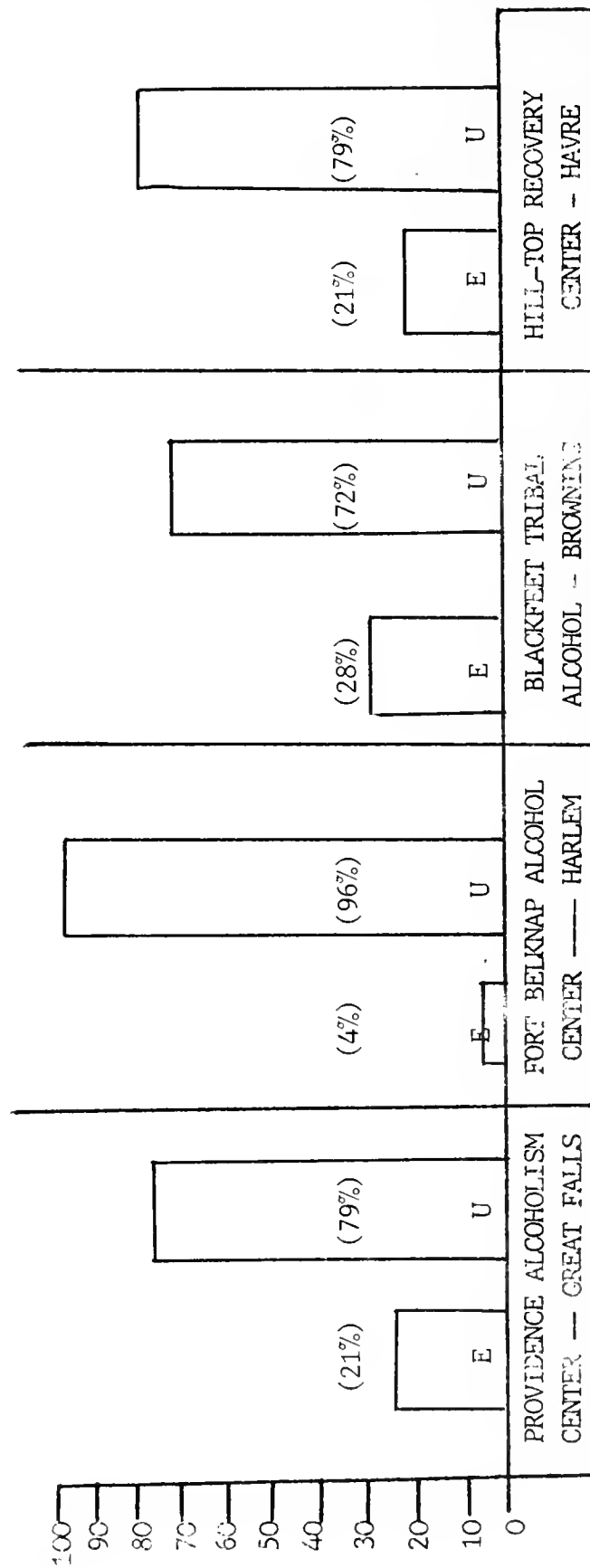
REGION III
ANALYSIS OF INCOME
JULY - SEPTEMBER 1976

1 = \$0-3600
2 = \$3600-8500
3 = \$8500-above



REGION II
ANALYSIS OF EMPLOYMENT
JULY - SEPTEMBER 1976

E = Employed
U = Unemployed



Per Capita Income

<u>County</u>	<u>1970</u>	<u>1974</u>	<u>Percent Increase</u>
Blaine	3,479	5,010*	44.0%
Cascade	3,755	4,947	31.7%
Choteau	5,443	11,378	209.0%
Glacier	2,893	4,574	58.0%
Hill	3,812	6,333	66.1%
Liberty	6,966	8,669	24.4%
Teton	4,337	5,460	25.9%
Toole	4,922	7,679	56.9%

*Regional Economic Information System Bureau of Economic
Analysis U.S. Department of Commerce

Region II

CENSUS

<u>County</u>	<u>Population (from 1975 provincial census)</u>
Blaine	6,800
Cascade	84,300
Chouteau	6,200
Glacier	11,600
Hill	17,900
Liberty	2,500
Pondera	6,900
Teton	6,500
Toole	5,300
TOTAL	148,300

*source: 1975 provincial census

REGION II

IV Region Survey:

The Regional utilization of alcohol formula funds has been administratively transferred from the Comprehensive Health Planning Regional Councils to the Region II North Central Montana Alcohol Board of Directors. The transition was described in the fiscal year 1975 State Plan. The regional alcohol board has only recently assumed this responsibility for Alcoholism planning and the system is not yet fully operational. The regional plans for alcoholism prevention and treatment are being developed and are included in this regional State Plan.

The Region II North Central Montana Alcohol Board of Directors is a tax exempt non profit organization which is separate and distinct from formal government structures; however, the nine members of this board are commissioners from the nine counties encompassing the boundaries of Region II. This Regional Alcohol Board receives input from other members who are county commissioners of the nine counties served by the region. In addition, substantial citizen input is channeled to the regional alcohol board through the advisory councils which are made up of residents of the several counties. This particular structure enables the Region II Alcohol Board to solicit input both officially, through the county commissioners, and also through the citizens advisory councils.

Existing professional alcoholism service providers in Region II and a brief narrative follow:

¹ Region II was phased out effective July 15, 1977.

Program Description
Fort Belknap Tribes Alcoholism

The Fort Belknap Indian Reservation is located in North Central Montana bordered on the north by the Milk River and lies between the towns of Harlem and Dodson. From these points it extends southward to the Little Rocky Mountains. It is approximately 40 miles wide on the north end and 25 miles wide on the south end containing 970 square miles.

The total potential of the Fort Belknap Tribes Alcoholism program has not been reached because of two major problems that we are confronted with a continual basis: The first is the astronomical problem of alcoholism on the reservation and its devastating effects on the individual, the family, and the social and economic balance of the Fort Belknap Reservation. Secondly, the lack of adequate funds necessary to counteract these problems.

The Fort Belknap Tribes Alcoholism Program provides services to approximately 1900 residents of the reservation with service potential for the total 3,800 enrolled members of the reservation. The Program provides services to alcohol dependent or addicted Indian people that includes, detoxification, halfway house residency, counseling, employment placement, treatment referral (long term), and health service referral to other agencies in the community.

The program has been in existence since 1974 and has provided a wide range of services to Indian people located in Blaine and Phillips Counties which comprise the reservation land base. The detoxification facility and services is relatively recent being established in March 1975. The entire program is sanctioned by the Fort Belknap Tribes Tribal Council and under the leadership of the Board of Directors and staff of the program.

It should be noted that the Project has only recently been operating with a budget of any sizable amount from various agencies. The majority of activity, prior to 1974, occurred on a volunteer basis with some help being provided on a state and local basis.

The program maintains five primary components. These are described as follows:

1. Detoxification

Client services to detoxify and counsel addicted or alcohol dependent individual. Full range of bed rest, food, and medical attention to client prior to discharge.

2. Recovery Home

Client services to residents who identify as alcoholics. Services include food, housing, counseling, group meetings, recreation, and work release program.

3. Outpatient Services

Counseling and transportation of clients to long term treatment. Visitation to community homes of client residence for purpose of individual or family counseling. Referral and transportation of outpatients to community health and employment agencies.

4. Alcohol Education

Presentation of alcoholism education to schools and other community contact structures for purpose of increasing their capability for client identification and referral. The sponsorship of community activities wherein potential clients can be identified and help given to take advantage of program services.

5. Inpatient Services

Identification of differential treatment plan for each client from Detoxification to Discharge and follow-up. Client placement and integration in program component suited to need. Contact with family and referral or legal agencies in the community. Completion of administrative work relative to component operations of program.

The proposed program would increase the salaries of current counselors and hopefully will keep them for a longer period of time, as well as provide them with remuneration commensurate to the tasks they perform. The two positions of Assistant Director and Drug Prevention Specialist would be utilized to provide a more in-depth and comprehensive dimension to the program. The Assistant Director would

assume many of the supervisory and practical program tasks, freeing the director of the program to function according to administrative requirements of the program and the needs of the people involved in the target area. The program director would also be freed to develop a comprehensive plan for drug prevention in conjunction with the Drug Prevention Specialist.

The Drug Prevention Specialist would operate primarily to determine the scope of alternatives available for the Fort Belknap Reservation. The person would sponsor community meetings and determine the exact capabilities of the Project and community to support a prevention emphasis among the youth and children located on the reservation. The individual would do the necessary planning and began action for a prevention effort functioning on the reservation within eight months of the initial employment date.

The travel funds applied for in this grant would be utilized by both of the two new staff members.

Program Need

The proposed program will provide services to residents of Blaine and Phillips Counties, commonly known as the Fort Belknap Indian Reservation. The number of individuals impacted by alcohol/drug related problems is 70% of the total population which would mean approximately 1300 people. The estimates of people affected by alcohol/drug related addiction or dependencies is based upon estimates released by the Montana Indian Commission on Alcoholism and Drug Abuse and the American Indian Commission on Alcoholism and Drug Abuse. Both of these Indian organizations provide a continuous range of services to Indian people and Indian projects concerned with alcohol and drug abuse recovery services.

The large number of people affected directly or indirectly by alcohol and drug addiction makes it impossible to provide the quality of service desired. The emphasis upon prevention has been completely ignored due to the immediate reaction for the need to provide services to victims of the addiction cycle. The administrative functions of the project have had to be completed as a secondary effort because the director has been needed as a member of the primary service staff.

The number of clients to be serviced by the program on an inpatient or outpatient basis is 350. This includes approximately 175 people served by the detoxification component, 75 are in the recovery home component, and 100 served on an outpatient basis in the community. It is anticipated that approximately 400 youth will be affected by and ultimately involved with program services due to the prevention focus.

It is anticipated that the primary sites for service delivery will be the program offices located in Harlem, Montana, and schools and recreational or meeting sites in the Fort Belknap Reservation community. All of the sites selected for meetings and eventual activities are located in a manner accessible to each community being serviced.

PROGRAM DESCRIPTION

HILL TOP RECOVERY CENTER

1. Agency's History

In September, 1970, our Alcoholism Program began with the Hill County Community Action Program, Inc. The title read Hill County Social Counseling.

It started in a small office located on the Community Action premises with one counselor. Those with alcohol related problems were referred to this person for counseling.

Two months later, the need was apprent for a live-in facility. There were no funds through Community Action to establish one; therefore, community involvement was sought. After a series of interest meetings, a board of directors was enlisted. They became incorporated, and then became landlords of a substantard hotel facility on the main street of Havre.

Plans were finalized in November, 1971, to move to the vacated Nurses Quarters at Deaconess Hall. The move was completed on November 23, 1971.

Since then, we have progressed from a half-way house to an approved treatment center with a staff of 9 people. We now have expanded our program to 8 counties. Advisory committees have been formed in all the counties serviced. An outreach counselor now serves our western counties and is stationed in Shelby. The senior outreach counselor also coordinates activities and functions in the 5 western counties serviced by Hill-Top.

2. Agency's Components

Basic Facility Operational Procedures

Facility Definition and Operation: Hill-Top Recovery is an incorporated, non profit, 20-bed inpatient, accredited treatment program licensed by the State of Montana which offers a residential setting for the treatment of the alcoholic who requires continuous care and treatment with specific therapeutic functions beyond those offered by emergency, intermediate, or outpatient programs. Hill-Top Recovery's target service area is the poverty sector population of the Montana counties of Blaine, Glacier, Hill, Liberty, Pondera, Toole, Teton and Chouteau.

The services provided by Hill-Top include individual and group counseling for the patient, individual outreach counseling for the outpatient, counseling for the family of the alcoholic, non-medical detoxification, and various educational and referral services.

The work schedule of Hill-Top Recovery's assistant administrator-house manager-counselor and houseman-counselor has been designed to assure a seven-day-a-week, 24 hour combination of duty and/or on-site/on-call coverage. All other counselors are on call on a rotating basis monthly. For emergency situations, the administrator is on call at all times.

The patients at Hill-Top Recovery receive and are exposed to a 30 day inpatient program covering a pre-selected group of informative and thought provoking topics.

Based on the client's individual needs, they may revert to a 30 day, half-way house situation on completion of the regular 30 day program.

Food Service : All meals for the patients of Hill-Top Recovery are prepared in our own kitchen and served in the lower level dining room. A dietician at our local college has assisted us in establishing a balanced nutritional menu suitable for the alcoholic patient. Breakfast is served at 7 a.m., lunch at 12 noon, and dinner at 5 p.m. Fresh fruit and snacks are available at all times. Pop and candy machines are also utilized for the patient's convenience.

Personal Hygiene: Clean clothing, drinking cups, towels, soap, tooth-brushes, combs, toothpaste or toothpowder, shaving equipment and other personal hygiene articles as required will be available for each patient of Hill-Top Recovery for his or her individual use.

Medical Services: Any patient, shall have the right to consult with the physician or dentist of his or her choice. Routine medical services are available through Northern Montana Hospital, at the Havre Clinic, or from the patient's private physician. If the patient has stated a preference for a certain physician and if said physician is available within the Havre area, in the event of an emergency, this physician will be contacted and the patient will be taken to the hospital. Should the patient's preference for a certain physician be unknown or should the patient's private physician not be a Havre based physician and, therefore, not readily available in an emergency situation, the "Doctor of the Month", as delegated by the Havre Clinic, shall be contacted and the patient will be taken to the hospital. Care is always provided to any resident in need, i.e. SRS, Welfare or Doctor.

Whenever necessary, a patient's detoxification will be provided on a non-medical basis by Hill-Top Recovery or, for medical detoxification, by Northern Montana Hospital. Hill-Top Recovery and Northern Montana Hospital have entered into a contractual agreement for detoxification services.

Hill-Top Recovery will accept responsibility for certain detoxification expenses. See "Admission and Discharge" for details regarding the detoxification expenses paid.

Upon entering Hill-Top Recovery, all patients are required to undergo a Tuberculin Tine Test or to provide Hill-Top with information with which Hill-Top may contact and obtain the results of the resident's most recent TB test. All patients required to undergo the TB patch test are given the test within the facility by the Hill County Health Nurse.

For those patients who qualify for State of Montana Vocational Rehabilitation assistance, physical medical examinations are provided by Vocational Rehabilitation.

As necessary, routine and emergency psychiatric aid is available to all patients at no charge. This aid is provided within the facility by a psychiatric social worker, on each Monday and Thursday afternoon from 1 p.m. to 5 p.m. As deemed necessary by Hill-Top Recovery counselors, patients may also be referred to a clinical psychologist, for psychiatric assistance.

Hill-Top Recovery is not a chemotherapy treatment program. Hill-Top encourages the equipping of the patient with the motivation to independently cope with tension, anxieties, and crisis situations without chemicals. Essential medications are permitted and are stored in such a manner that the use of such medications can be restricted. Qualified staff personnel administer all medications as directed by a physician.

Standard first aid equipment is available for emergency and routine use. The methods for cleaning, handling, and storing of all medical supplies and equipment shall be such as to prevent the transmission of infection through their use.

Comprehensive Treatment Services and Length of Stay

Hill-Top Recovery's Treatment program includes four phases of treatment. Phase One is "Observation and Detoxification", Phase Two is "Thirty Day Inpatient", Phase Three is "Inpatient Halfway", and Phase Four is "Outpatient". These treatment phases are described below.

Phase One: Observation and Detoxification: Upon referral of an intoxicated person to Hill-Top Recovery, the person is observed and, if severely intoxicated, is admitted to Northern Montana Hospital for medical detoxification to:

1. Assure safe and complete withdrawal from alcohol and/or other mood changing chemicals,
2. Examine the person's general state of health, and
3. Determine the extent to which other hospital services may be necessary should the person become a patient of Hill-Top Recovery.

If severe intoxication is not evident, the person will be admitted into the Hill-Top Recovery 72-hour, supervised, non-medical detoxification program.

When detoxification and withdrawal are completed, whether medical or nonmedical, the person is then given the option of entering Hill-Top Recovery's 30-day inpatient treatment program.

Phase Two: Thirty-Day Inpatient Treatment: After withdrawal, the person may begin a thirty-day period of inpatient therapy under the guidance of the counselor assigned to him or her, and designed to assist the patient to:

1. Identify his or her illness,
2. Accept his or her condition as a chronic illness,
3. Formulate an individualized treatment plan, known as the Continuing Recovery Plan (CRP), to be prepared, maintained on a current basis, and tailored to meet the needs of the individual patient (see CRP form in Attachment), and
4. Become familiar with the Twelve-Step Program of Alcoholics Anonymous which, in practice, has proven effective.

During the patient's thirty-day inpatient therapy, the patient is required to remain on the Hill-Top Recovery premises. Exceptions are allowed only for emergencies.

Phase Three: Inpatient Halfway Treatment: At the end of the patient's thirty-day inpatient therapy program or when, at the counselor's discretion, the patient is ready for discharge, the patient may begin thirty days of inpatient halfway treatment. The "halfway" treatment phase is available to those individuals which the counselor feels would have undue difficulty in adjusting to general society or to individuals who do not have a home or job available.

During the inpatient "halfway" phase, the patient is free to use the Hill-Top Recovery facility as a "home base" while making arrangements for living quarters outside the facility and while seeking employment. The patient's counselor will assist him/her in these endeavors with referrals. Individual, psychiatric, and group therapy counseling are available for the patient during the "halfway" period and the patient is encouraged to continue to take part in such counseling during his halfway period and after his discharge.

Phase Four: Outpatient Treatment: Because alcohol and other drug dependence is a harmful, chronic condition, each former patient of Hill-Top Recovery is expected to remain in regular contact with Hill-Top for a period of two years. Group therapy sessions are also designed to meet the special problem areas of former residents and to enable him or her to continue with continuity through the stages of recovery. Former residents of Hill-Top are expected to return for therapy sessions, consultation and counseling with staff members. Should such regular visits to Hill-Top Recovery not prove feasible for the former resident, the former resident shall be assisted in making contacts with clinics, Alcoholics Anonymous, social and welfare agencies, and/or other approved treatment programs suitable for follow-up care upon discharge from Hill-Top. The outreach counseling staff has been instrumental in starting A.A. meetings in Sunburst, Bynum, Harlem, and Conrad. Alumni patients of Hill-Top are now actively participating in these programs. Due to the large area covered by the center, our new outreach counselors will be able to re-inforce and maintain a better aftercare and follow-up program. Continuing contact with these former patients has a definite therapeutic function and is important to the rehabilitation process. Periodic visits are noted by the

counselors and entered in the patient's file. The Hill-Top Recovery referral program for the former resident shall be maintained to effect total and complete recovery and rehabilitation.

Length of Stay: As noted above, the usual length of the patient's residency for treatment is generally thirty days, with an additional thirty days inpatient "halfway" treatment available. To maintain the program's flexibility, and to enable the counseling staff to plan a treatment program for each individual's specific needs, the initial thirty days and the thirty days "half-way" residency are not viewed as mandatory. Sometimes shorter treatment periods are necessary for a patient. Employers sometimes will not let the employee take a full 30 day lay off. In these cases it becomes necessary to offer the patient a more concentrated program to establish and maintain his sobriety. Our treatment program is flexible and can be adjusted to a 10 day or 21 day situation depending on the patient and his needs. Needless to say, a full 30 day program is recommended for the person that has a desire to gain and retain sobriety.

The Physical area served:

1. The seven counties served are located in the North Central Montana area. The total square miles of the counties involved are 17,700 miles. The counties are:

Blaine County - City of Chinook
Hill County - City of Havre
Liberty County - City of Shelby
Toole County - City of Shelby
Glacier County - City of Cut Bank
Teton County - City of Choteau
Pondera County - City of Cut Bank
Chouteau County - City of Fort Benton

2. The total population of the eight county area is 63,300. The alcoholic population is 9,135.²

Others or ripple effect 6-1 = 54,810³

3. Ethnic or economic sub-populations for whom services are specifically tailored:

With funds received from the state grant it will relieve HEW funding so the center may hire an Indian outreach worker. His responsibility will be to work urban Havre. This service will be in addition to our regular contacts on a townwide level. It is anticipated that this additional function will bring the center into closer contact with the Indian population and its problems.

4. The number of target population clients we expect the project to serve over a 12 month period:

We expect to provide a 30 day treatment (inpatient) program for 350 people. We expect to provide outpatient counseling services for 2,400 people.

²This figure is significantly higher in percent than other Regions.

SOURCE: Alcohol Abstracts, December 1, 1974,
American Business Men's Research Foundation,
Suite 705, Stoddard Building, Lansing, Michigan
48933.

³As influenced by data 2, the ripple ratios (6:1) projects 86.6% of population as effected.

SOURCE: Rocky Point Fall Conference - 1976

PROGRAM DESCRIPTION

CITY/COUNTY ALCOHOL - GREATFALLS

History

The City-County Health Department became involved in alcoholism treatment planning and programming in January of 1975. The first Alcoholism Services Development Plan was published in May and implemented in July, 1975. Under a new organization setting, the City-County Health Department became the overall administrative agent with respect to dispensing local, state, and federal tax dollars in the field of alcoholism treatment. Services such as planning, reporting, and program coordination and development have been provided directly, however, alcoholism treatment per se has been handled through the contract for service mechanism with other local programs and agencies. These service agencies have also provided efforts in the areas of alcoholism education and outreach.

The Providence Center in Great Falls has been the principal provider of alcoholism treatment services (intermediate and outpatient care), with both hospitals having provided emergency services, and the Northcentral Montana Community Mental Health Center having provided consultant and limited direct services to alcoholics.

It should be clearly understood by all involved that in the first year's (FY 75-76) planning and program implementation, the effort was to maintain previously existing levels of alcoholism services. It was felt that this was a realistic approach based upon the limited availability of local and state financing. The Alcoholism Services Plan for FY 75-76 assigned to the Health Department's alcoholism services coordinator the responsibility for studying the need for additional alcoholism treatment services including sub-acute detoxification, expanded outreach efforts, inpatient care, expanded outpatient care, and follow-up services.

Expansion of services should begin this fiscal year, with the ultimate goal of providing the truly comprehensive continuum of care necessary for effective treatment of this complex disease.

Need for Services

The alcoholism treatment services described in this application are provided principally to the residents of Cascade County, however the services are also provided as appropriate to residents within a much wider geographical area. An estimated 15% of the clients receiving care in the last fiscal year were from outside the boundaries of Cascade County.

The provincial census from 1975 lists the population of Cascade County at 84,300 with an American Indian segment of 1,870, or nearly 2%. The Montana State Plan for Alcoholism in 1973 indicated that the County had a higher percent of total liquor sales than its percent of state population; the County is probably comparable then to the state as a whole in numbers of alcohol abusers and alcoholics. Using the figure of 8.5% of the population also taken from that 1973 report, Cascade County would have approximately 7,165 alcoholics. The ripple effect or those affected by alcoholism is 6 to 1, or 42,990 (From Rocky Point Conference in September, 1976).

The project proposed would expect to provide alcoholism services to approximately 420 individuals, and alcoholism education and counseling to approximately 150 individuals from the target population. Educational training would also be provided to health care professionals, teachers, clergy, social workers, businessmen, labor and civic groups in the community education and the outreach components of the project.

Project Philosophy

It is the philosophy of this project that there is an urgent need to search out and to bring the alcoholic into the treatment system, and to attempt to provide treatment within that system according to the individual needs of each client. It is accepted that the cause of alcoholism is not yet known and that there are several approaches to treatment that have been demonstrated to be effective. The alcoholic individual should understand this philosophy and should be free to opt for any mode of treatment, whether it is available locally or not. The project considers alcoholism a disease that can be treated to an arrested or non-active state of health.

Project Planning

Mission Statement: To provide a comprehensive alcoholism services system, accredited by state and national standards, for effective and efficient efforts in the prevention, treatment, and rehabilitation of the disease alcoholism.

Problem Statement: As indicated in the History section of this plan, project efforts to date have attempted to maintain those alcoholism treatment services that had existed in the community for several years, with the primary aim of improving those services from an administrative and patient care standpoint. As is documented by the responses from the community to the alcoholism services public participation questionnaire of March 10, 1976 (see Addendum D) that primary aim of maintaining and improving existing treatment resources was generally successful.

A review of those same public participation questionnaires, along with any manual on the development of alcoholism treatment services (see the National Association of Counties' A Practical Manual for County Officials on the Treatment of Alcoholism; The National Institute on Alcohol Abuse and Alcoholism's Developing Community Services for Alcoholics; or the Joint Commission for Accreditation of Hospitals' Accreditation Manual for Alcoholism Programs) quickly reveals the lack of a comprehensive network of services in this community. Although development of a total services system cannot be expected to occur overnight, it is important that steady improvement be made both with respect to upgrading existing service components and with respect to developing additional services.

In the area of administration and services coordination, it is felt that the purchase of services through contract on an individual client basis is the proper method of operation for the program. For the present time, the City-County Health Department appears to be the most appropriately led administrative agency. Three major needs are seen in this administrative area and must be addressed in this plan:

1. The Health Department needs to obtain a staff member with direct expertise in alcoholism treatment in order to more critically assess, and to direct improvements in patient treatment planning and care.
2. The treatment system is (and should be) providing services to residents of other counties. A functional service area needs to be involved from both a financial and program standpoint.
3. Attention needs to be paid to the poor record of collecting fees for treatment services from the individual clients.

In the area of emergency services, there is a need to proceed with development of a sub-acute detoxification center, where people can be cared for at a substantially lower cost than in hospitals, and can also be provided with extensive motivational counseling to pursue rehabilitation. It would appear, however, that such a facility is at least a year away, and in the interim improvements are needed from many sectors. Physicians and hospitals should consider a more liberal policy of admitting certain alcoholics for overnight care, while Providence should receive reimbursement to enable them to contact these people in the hospital the next day to encourage them toward treatment. Law enforcement must realize that hospitals cannot accept all inebriates and should review their procedures and utilize their authority to detain in protective custody in applicable situations. The Providence Center should be in a position to provide detoxification services to some of those clients the hospitals and physicians determine as not needing acute care. Emergency commitment should be explored as a possible solution to the chronic revolving-door alcoholic, with involuntary commitment to a treatment center also applied as necessary. Payment for emergency medical services for alcoholism should remain primarily the responsibility of the medical welfare programs and agencies, however, a limited subsidy should be provided in order to assist the treatment facilities in recovering some of the expenses incurred.

The most important area of service that needs to be developed at this time is that of outreach development and coordination. As is pointed out in the guides to developing services, many services are already available in the community, and simply need to be identified and involved. What is needed is to introduce into the competence of all social and health agencies the capacity and the desire to contribute to the care and treatment of the alcoholic. The physician, the hospital nurse, the clergyman, the mental health worker, the social worker, the school counselor, the public health nurse and the other human service agents can all play an important part in dealing not only with the alcoholism, but with the many and varied related problems and with the needs of the alcoholic's family as well.

Intermediate or residential care is at present the primary mode of providing alcoholism treatment in this area. Although entirely appropriate for many individuals (especially for older, chronic, late stage alcoholics) this is a very expensive form of care and the more efficient format of outpatient care needs to be encouraged whenever applicable on an individual client needs assessment. Developing a closer working relationship with the State Alcoholism Treatment Center at Galen would seem to offer some potential toward relieving the demand for intermediate care beds at the local level. Effective procedures for client referral (in both directions) would be necessary to proceed with this approach and should be developed at the earliest possible opportunity.

Outreach efforts described previously should facilitate earlier identification of early and middle stage alcoholics, which should result in an increased provision of treatment services on an outpatient basis.

Aftercare services provide reinforcement to those clients successfully completing a treatment program element. Efforts last year to incorporate aftercare through the group therapy format were not successful, and it was agreed that with the present type of client, aftercare on an individual or one to one basis would be of most benefit.

Follow-up services can be useful in two ways: (1) To reinforce treatment or to encourage additional treatment if appropriate and (2) to develop statistical data on the success of the program after a one or two year period. Very minimal follow-up has been done in past years, and efforts should be initiated on a limited basis at this time.

Community education and prevention efforts remained at minimal levels in the past year. Short range planning should look at development of a full-time staff position to work exclusively in this area. This position would be charged with developing a program to assist the educational efforts of public school teachers and others, to develop community concern regarding the problems of alcohol abuse and alcoholism, and to develop community awareness of the resources available to treat and control alcoholism.

BLACKFEET ALCOHOLISM PROGRAM

PROJECT PLAN AND SUPPORTIVE DATA

The blackfeet Alcoholism Program presently operates on a combined Detox unit and Half-Way House. There are 12 beds in the Half-Way House and 10 beds in the Detox portion, 4 of which are for women and 6 are for men. We operate at capacity and are full most of the time with a 30% turnover. The circumstances have changed since we first opened up in August of 1974. At that time we had a very large turnover and repeat list. As of now, we have succeeded in keeping our clients for a longer time and taking the full treatment instead of just getting dried out. We feel that we have changed the life style of 80% of our clients. We work closely with the Public Health Service hospital and utilize them for emergency care. The Public Health hospital is located approximately 1800 feet from our facility.

Our Administrative Staff is as follows:

Blackfeet Tribal Health Board
Director: Margaret Kennedy
Assistant Director: Vacant
Detox Supervisor: Berna Running Fisher
Treatment Supervisor: Charles Momberg, Jr.

At present time we service Detox clients with medical (PHS) and basic physical care such as detoxification, understanding attendant care, close observation, food and shelter. After five days, if a client decides to enter our ten day treatment project he/she becomes a Half-Way House client involved in a short term treatment and aftercare component. The short term treatment consists of 160 hours of intensive alcoholism education and counseling on a one to one basis and group sessions. We have 12 beds in the Half-Way House which are nearly always filled to capacity.

For what we propose to do in the future we have a competent staff, including counselor/attendants, outreach counselors, follow-up counselors and administrative staff, which include director, assistant director, bookkeeper/secretary, Detox supervisor and treatment supervisor.

The Blackfeet Alcoholism Program is located in Browning, Montana, the urban hub of the Blackfeet Indian Reservation. The Blackfeet Reservation is located in the northcentral part of Montana, bordered on the west by Glacier National Park and on the north by Canada. It is almost totally included within Glacier County, although Glacier County has a large center outside of the Reservation, namely Cut Bank, the county seat. A small portion of the Reservation is located in Pondera County, with the county seat located in Conrad. The current population on the Reservation is 7,400 in a 3,300 square mile area. We are located in the inner portion of the township. The closest town would be the county seat located 37 miles east of Browning. This would include our three Indian communities: Starr School 18 miles, Heart Butte 35 miles, and Babb 42 miles, East Glacier 12 miles, St. Mary 35 miles and Blackfoot 14 miles. Since we service the whole Reservation, our target population is 7,400. Members of our Tribe needing alcoholism services including family members would be 75%.

The average income for our area is approximately \$1,200.00 per annum, so this definitely puts us on the peverty level. The level of unemployed is 38%, the suicide rate is relatively low, 12%, however the attempts are somewhat higher, 40%, admitted alcoholics are 60%, but unadmitted rate is somewhat higher, more likely 85%.

The Blackfeet Alcoholism Program maintains the philosophy that alcoholism treatment is best achieved in a familiar environment. The devastating effects of alcoholism and alcohol abuse to the individually, family, social and economic balance of the Blackfeet Reservation is the most severe social problem we have on the Reservation. Our short range goals are to continue in our capacity of detoxification, treatment, outreach and follow-up care. Since complete abstinence is unrealistic, we feel that we have improved our clients lifestyle by keeping some of our hard core clients sober for a given amount of time. The work success is presumptuous and we feel that in keeping some of our clients sober, attending sessions and A.A. meetings and gaining them employment that we have had some semi-success in improving their mode of living. Our overall expectation is to teach our clients self-determination, not only to be able to exist in a white man's world but, also be able to retain their Indian culture in a workable way. We also contemplate a diversified farm-ranch situation for clients leaving our Half-Way House.

Our program is the only existing facility for alcoholism in our catchment area providing intensified detoxification and halfway house facilities including treatment. We do work closely with the Indian Health Service and law and order. We are the only State certified Indian Alcoholism Program in Montana. We have passed all regulations for the licensing law and regulations adopted by the Montana State Board of health and Environmental Sciences. We also complied with the recommendations made by Robert Racine, Environmental Health Technician, Browning, Montana. His report was sent to Billings and our Detox unit is fully capable of implementing our services. The IHS provides medication and physicians services to our clients that have physical problems and then will either admit them to the hospital or refer them to our facility. The law and order refers clients to us after making their own evaluation on their case.

The new services proposed will be more Outreach and follow-up services, if we are able to hire additional staff. Through more training of our present counselors, their duties can become more diversified. For the program career development we are implementing enough training sessions to work toward an A.A. degree through Flathead Community College. Our Area Health Board has discussed that alcoholism among Indians is the number one problem. Because of this, the IHS is funding the Detox units on the Reservation in Montana and are increasing the original grants. We have been granted a plot of land in the country and we are working toward a farm-ranch facility for clients leaving the Half-Way House which we hope to make self supporting through cattle and a small amount of farming with client labor. This certainly relates to our program goals which is sobriety and self-determination. The methods to accomplish this can be obtained through the Tribal Council.

Our eligibility requirements are men/women coming in with a desire to gain help to become sober and staying sober. Since we are nationally funded, we do not turn anyone away of any ethnic group. Of course, we do try to determine whether we are being used for a sleeper or not.

We have utilized many of our local agencies such as A.A., AL-ANON, for meetings and lectures, Public Health Hospital for medicine, physical care and referral, churches for lectures, psychologist in residence for one to one counseling and group sessions, law and order for referrals and transportation, ambulance services, Mental Health staff for training and counseling, Vocational Rehabilitation for employment aides, welfare office for child welfare services for clients, nursing home for client employment, Great Western Pencil Factory for client employment, Tribal office for facility, utilities and advisory and insurance, Mainstream (CETA) for program employment, a cook and counselor, TWEP for program employment, Public Health Nurses inservice training for staff and lectures, local Health Board advisory, community involvement for lectures are not available with the exception of Welfare Department, Mental Health, church, and outside A.A. resources.

Continuity and follow-up has been one of the snags in our program because of short staffing. In the future we hope to hire follow-up counselors because it isn't any use to sober a client up, give him treatment and then put him back on the street. The only follow-up we have been able to do is try to commit them to return to sessions and A.A. meetings, and periodic checks at their homes.

We now have a Detox unit with 10 beds, four for women and six for men. These are dorm type rooms. We also have a kitchen and dining room with facilities for 24 people and two men's bathrooms and one women's bathroom. We have four offices for the administrative staff and twelve beds in the Half-Way House. One room is a five bed dorm and the other rooms have two beds in each. We have a private room for a Halfway House manager. There is a large day room with one pool table, a television set and adequate room for movies and sessions. We do have a psychologist in residence who is our consultant and divides his time between here and the hospital.

Our project director spends 100% of her time at the Center, meaning the eight hour work day. She also takes calls at her home and is always on call if needed to return after working hours.

The overall staffing is of American Indian descent and all are from the Blackfeet Indian Reservation. This would seem to balance out our ethnic composition as we service 98% Blackfeet Indians from this Reservation. As you can see from our chart, we do have a balance of management and treatment personnel. This would be five managerial and seven treatment. Our psychologist in residence has a Master's degree. Our assistant director has two quarters left to gain a BA degree majoring in psychology. Two of our staff have an A.A. degree majoring in vocational nursing. The rest of the staff would be called non-degree professionals from staff in-service training and on the job training. We have had no objections to hiring recovering alcoholics for the reason that we felt that an alcoholic who had been through

hell that only another drinker knows could really understand. However, we only were semi-successful with some of the recovering alcoholics either from too many pressures or not being able to handle prosperity. We still have no objections to hiring a recovering alcoholic.

At the present time, we have had cardiopulmonary resuscitation training for the entire counselor staff. After staff meetings on Monday morning, we have a full hour session on counseling and alcoholism education given by Joe Plumage, psychologist, doctors from the hospital and members of the Mental Health Staff. Members of our staff have had training in blood, pulse and respiration and procedures to handle D.T.'s. Previously, we sent two members of our staff to counseling training in Billings. We also have one of the doctors at the hospital come down every other Thursday to give the staff in-service training. We also utilize the Public Health nurses for training when they are available. We also have self awareness sessions every week. Most of these sessions are held on the counselors own time. All of our counselors are attending a drug and alcohol abuse class once a week which is qualified for three college credits through Flathead Community College. We are working toward getting A.A. degrees for all of our counselors.

We keep dual charts on all our patients. One is a medical chart. We also keep medication sheets for each shift. In our medical charts are kept vital statistics and medical data from each shift. In our treatment charts are personal counseling information, which are kept confidential in a locked file. All files are duly signed by the attendant on duty, as well as the medication sheets. We also keep a book of admits and discharges. This makes it easy to find repeats. We also have a file for total number of clients and pertinent information monthly.

The program records kept are weekly staff meeting minutes, board meetings every Wednesday. Monthly reports are sent to the Health Board and all advisory board members and the area office in Billings. Our bookkeeper sends in our quarterly financial records, annual tax reports to IRS and State Employment Service. We will have a quarterly report going to NIAAA. All members of the staff will be responsible for data gathering. A member of the Health Board will evaluate our program.

Throughout all phases of evaluation, continual evaluation of community acceptance from the total population as well as other groups will be undertaken to determine the acceptance of such goals as education, rehabilitation, and prevention. Based upon surveys and evaluations, the purposes, objectives, and programs at the Blackfeet Alcoholism Program will be developed. During the final phase of program achievement, surveys of clients, past and present who have received treatment will be undertaken to determine whether or not the program and its methods are meeting individual recipient needs, also follow-up on clients who received referral counseling, one to one care, family, marriage, outreach counseling, local community education and career development.

We have reapplied for a renewal grant from NIAAA as our funding will expire March 1, 1976. At the present time we are getting \$40,000.00 per annum from NIAAA. We have been warned not to ask for an increase in the original grant because of President Ford's cut-back in alcoholism funds. Our services have progressed so much that the budget for a year is more like \$88,000.00. In order to keep rendering these services both in quantity and quality, we must have enough money to operate on a full time high performance basis.

Our relationship with IHS has been along the lines of excellence. We are grateful for the increase in Detox monies and will enable us to give better quantities and qualities of service in the Detox unit. Since we operate at capacity at all times, perhaps this increase will keep us going in our plans to enlarge our quarters and make room for potential clients. We hope to continue our fine relationship with the Indian Health Service and keep working together to obtain a high degree of achievement in the alcoholism field.

NOTE: Due to bringing our program into the schools three days a week for education and prevention of alcohol and drug abuse, we have noticed an increased strain under our staff component. In short, we are sadly understaffed. Also, we have incurred more expenses through becoming deeper involved in our services and the budget should tell in exactly what area help is needed.

The incidence of alcohol related cases that have gone through the Blackfeet Tribal Court in the year 1975 is 3,500 according to court records.

According to IHS Hospital records the incidence of alcohol related cases is 20% Mental Health caseload, alcohol related patients seen 60%. Alcohol related accident cases were 17%, alcohol related motor vehicle accidents 35% and 49% alcohol related injuries inflicted by others.

In the year of 1975, our Center served 648 clients. The IHS Hospital is available to serve alcoholism clients if they require hospitalization and the ONAP program has one alcoholism counselor who only serves the ONAP employees. He sometimes uses our facility for this purpose. There is no monetary exchange but we do cooperate and the local programs utilize each other.

Consideration should be given to these alcohol service providers for the fine effort put forth with the limited amount of funds to work with in the past. The dedication factor involved with all service provider personnel cannot be measured other than their mere existence. It has been acknowledged at the various county advisory council meetings that the average salary within the existing structure is a disgrace. All programs have experienced losing personnel after many years of on the job training to other programs in neighboring states due to the difference in salaries. Dedication will not last forever: The State of Montana has lost too many good native Montana Alcoholism counselors which our neighboring states realize as an asset to them.

Due to past experiences in Region II, anticipated income from other sources should not be required until the contractees have had the time required to demonstrate to other sources, i.e.; private funds etc., that the service they are offering with total funds from the State of Montana is feasible. In the past anticipated income sources have withdrawn their appropriations and have caused an additional hardship on the currently less than adequately funded program.

REGION II TOTAL BUDGET FOR FY 1978 - Beginning July 1, 1977, Ending June 30, 1978

Blackfeet Tribes Alcoholism	\$ 50,000.00
City/County Alcohol	574,871.25
Fort Belknap Tribes Alcoholism	27,900.00
Hill-Top Recovery Center	328,315.00
Region II Addictive Disease	
Resource Development Specialist	<u>40,000.00</u>
	\$1,021,086.25

REGION II

Projected Need for Alcoholism Services

Blackfeet Tribes Alcoholism Center

1. Personal Services:

Salaries:

five alcoholism counselors at \$8,580 per counselor.	\$42,900.00
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Travel:

9,666 miles x 15¢	1,450.00
per diem & meals.	900.00

Training:

five week seminar @450 per 5	2,250.00
consultant, @625/5 days 4x1 year.	<u>2,500.00</u>

TOTAL	\$50,000.00
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PROJECTED NEED FOR ALCOHOLISM SERVICES

CASCADE COUNTY, MONTANA

DECEMBER, 1976

1. EMERGENCY SERVICES

A. Acute Detoxification

1. 2 beds @ 365 days @ .70 occupancy rate @
\$120.00/day = \$61,320 .
2. 30% from alcoholism services tax. = \$18,396.00
- 60% from public and private insurance. = 36,792.00⁴
- 10% from client or other services. = 6,132.00
- TOTAL \$61,320.00
3. Average length of stay of 3 days would
serve 170 clients.

B. Sub-Acute Detoxification

1. 14 beds @ 365 days @ .70 occupancy rate @
\$55.00 per day = \$196,735 .
2. 90% from alcoholism services tax. = \$177,061.50
- 10% from client or other sources. = 19,673.50
- TOTAL \$196,735.00

C. Transportation

1. Ambulance Service .
- 25 emergency runs @ \$58.00 . = \$ 1,450.00
- 111 patient transfers @ \$50.00 . = 5,550.00
2. Inter-agency transportation including
client transport to Galen and sub-acute
detoxification pick-ups . = 3,000.00
- TOTAL \$ 10,000.00
3. 100% from alcoholism services tax . = \$ 10,000.00

⁴ Payment from health plans is unlikely to increase lacking legislative action.

II. TREATMENT SERVICES

A. Intermediate (Residential) Treatment

1. 25 beds @ 365 days @ .85 occupancy rate.
@28.00/day = \$217,175
2. 85% from alcoholism services tax . = \$184,598.75
15% from client and other sources. = 32,576.25
- TOTAL \$217,175.00
3. Average length of stay of 25 days would provide service to 310 clients.

B. Outpatient Treatment

1. 110 clients @ 40 hours @ \$14.00/hr. = \$ 56,000.00
2. 150 clients @ 15 hours @ 14.00/hr. (DWI Countermeasures). 31,500.00
- TOTAL \$ 87,500.00
3. 85% from alcoholism services tax. \$ 74,375.00
15% from client and other sources. = 13,125.00
- TOTAL \$ 87,500.00

C. Comiciliary Care/Halfway House

1. 20 beds @ .80 occupancy rate
@ \$14.00/day = \$31,760.
2. 25% from alcoholism services tax. = \$ 20,440.00
25% from SSI payments. = 20,440.00
50% from Voc. Rehab., Adult Probation, and other. = \$ 40,880.00
- TOTAL \$ 81,760.00
3. Average length of stay of 200 days would provide services to 29 clients.

III. OUTREACH/FOLLOW-UP SERVICES

- | | | |
|---|---|----------|
| 1. Indian, Clergy, Employee Assistance, Providence Center, Court Commitments, Information & Referral. | = | \$50,000 |
| 2. 100% from alcoholism services tax. | = | \$50,000 |

IV. PREVENTION/EDUCATION

- | | | |
|---------------------------------------|---|----------|
| 1. School and Community Services. | = | \$20,000 |
| 2. 100% from alcoholism services tax. | = | \$20,000 |

V. MANAGEMENT SERVICES

- | | | |
|--|---|----------|
| 1. Planning, Resource Development, Evaluation Inter-agency Coordination, Financial accountability. | = | \$20,000 |
| 2. 100% alcoholism services tax. | = | \$20,000 |

Total cost for comprehensive network of services to be provided from alcoholism services tax = \$574,871.25⁵.

⁵ Based on foregoing needs budget, this amount will not be available.

PROJECTED NEED FOR ALCOHOLISM SERVICES

HILL-TOP RECOVERY CENTER

HAVRE, MONTANA

This plan will have two parts and therefore it will be flexible according to funds available in the next fiscal year. It will be flexible as to the counties who choose to participate in Hill-Top's services. If the legislature goes as planned 40% of alcohol money will be returned to the counties earmarked for alcoholism services so counties will have the ability to choose and do what they see as priorities. This plan will be based on the assumption that the legislature will pass the needed increase in alcohol tax for alcoholism services and there will be no match money required from cities and counties.

The target population priorities are:

1. The average family oriented working alcoholic and family.
2. The youthful alcoholic and family.
3. The re-employable alcoholic and family.
4. The chronic alcoholic (public inebriate, skid row type).

The priorities for services are:

1. Treatment Intermediate.
 - A. Family inebriated working alcoholic, youthful alcoholic, and employable alcoholic and their families will receive 30 days of alcoholism treatment.
 1. This service provided at Hill-Top facility to people of all counties who choose to participate.
- II. A. When Client is in 30 day treatment plan at Hill-Top his/her family will be provided with alcoholism education and counseling.
 - B. When client leaves center counselor in appropriate area will provide supportive and aftercare services.
- III. Detox or Emergency implemented to relieve hospital and law enforcement agencies from workload created by chronic alcohol.
 - A. Non-medical provided at Hill-Top.
 - B. Medical provided in hospitals by contract with Hill-Top. Hill-Top to negotiate and administer contracts to hospitals and physicians.

Personnel & Fringe	\$152,000.00
Travel	6,000.00
Consultant	6,000.00
Medical Contract	5,000.00
Training	2,000.00
Literature	2,600.00
Groceries	13,300.00
Coffee	3,600.00
Communications	2,100.00
Insurance	1,100.00
Repairs & Maintenance	5,200.00
Equipment Leasing	1,100.00
Rent, Building	5,200.00
Furniture & Equipment Purchases	7,100.00
Medical Supplies	1,200.00
Office Supplies	2,000.00
Housekeeping	1,300.00
Postage	800.00
Dues, fees, subscriptions, advertising	1,800.00
Miscellaneous Supplies	<u>1,500.00</u>
TOTAL	<u>\$220,900.00</u>

Part II

This consists of outreach counselors in seven counties whose main purpose is to identify and refer alcoholics to treatment at Hill-Top or the appropriate agency. To provide counseling to families and aftercare to clients when he returns home. To work with schools, other agencies and the community in areas of public awareness and education. Each county is responsible for medical detox for people from their area. Contracts for this to be negotiated by Hill-Top for this service and Hill-Top for this service and Hill-Top will administer funds for this contract.

Medical detox at the community level has not been a serious problem in the past. With a full time counselor in each community the problem should be adequately taken care of. If there is no need for medical detox the client will be transported to Hill-Top for non-medical detox.

The counselors in the seven outlying counties will work closely with the local alcoholism committees. Whatever these committees see as necessary needs in their communities will be fed as information to Hill-Top, who will then attempt to fill these needs.

Part II of this plan will increase the present staff by 3½ people, and will give each county one full time counselor.⁶

Blaine County

One counselor & benefits	\$11,600.00
Travel	450.00
Phone	150.00
Training	300.00
Medical contract	<u>1,000.00</u>
TOTAL	\$13,500.00

Liberty County

One counselor & benefits	\$11,600.00
Travel	540.00
Phone	100.00
Training	300.00
Medical contract	<u>1,000.00</u>
TOTAL	\$13,540.00

⁶ It appears that not all counties will participate in Hill-Top outreach for the whole year.

Chouteau County

One Counselor & Benefits	\$11,600.00
Travel	1,125.00
Phone	600.00
Training	300.00
Medical contract	<u>1,000.00</u>
TOTAL	\$14,625.00

Toole County

One counselor & benefits	\$14,400.00
Travel	1,980.00
Phone	600.00
Training	300.00
Medical contract	<u>1,500.00</u>
TOTAL	\$18,780.00

Glacier County

One counselor & benefits	\$11,600.00
Travel	2,430.00
Phone	600.00
Training	300.00
Medical Contract	<u>1,500.00</u>
TOTAL	\$16,430.00

Pondera County

One counselor & benefits	\$11,600.00
Travel	1,620.00
Phone	400.00
Training	300.00
Medical Contract	<u>1,000.00</u>
TOTAL	\$14,920.00

Teton County

One counselor & benefits	\$11,600.00
Travel	2,220.00
Phone	500.00
Training	300.00
Medical Contract	<u>1,000.00</u>
TOTAL	\$15,620.00 ⁷

TOTAL PART II	<u>\$107,415.00</u>
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TOTAL PART I	<u>\$220,900.00</u>
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TOTAL PROJECT	<u><u>\$328,315.00</u></u>
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⁷ Counselor involved has current four-county responsibilities, i.e., Teton, Liberty, Pondera and Toole.

IV. Community Awareness and Education.

These services are presently being provided by Hill-Top to the counties of Hill, Blaine, Liberty, Chouteau, Toole, Glacier, Pondera and Teton. Hill-Top is accredited by the State of Montana for these services and approved by the State of Montana.

PART I

The first part will fund all the services provided in the physical plant at Hill-Top. This is a constant cost which includes intermediate care to 350 clients from this eight county area and/or from any area in Montana in order to maintain 100% occupancy. Non-medical detox services provided for 120 clients.

Part I will increase Hill-Top staff by 3½ people, one houseman and ½ part-time secretary.

Projected Need for Alcoholism Services

Fort Belknap Tribes Alcoholism Center

1. Personal Services

Assistant Director	\$9,000.00
Alcohol Prevention Specialist	9,000.00
Alcoholism Counselor - NIAAA funded	1,500.00
Alcoholism Counselor - NIAAA funded	1,500.00
Alcoholism Counselor - I.H.S. funded	1,500.00
Alcoholism Counselor - I.H.S. funded	<u>2,400.00</u>

\$26,400.00

\$26,400.00

2. Travel

5840 miles at 15¢ per mile	876.00
per diem & meals	<u>624.00</u>

\$1,500.00

1,500.00

TOTAL

\$27,900.00

PUBLIC HEARING IN REGION II
Review Week - December 6 to 11, 1976
Public Hearing Week - December 13 to 16, 1976

Areas of special need in the field of alcoholism were identified during the public hearing week of Region II State Alcohol Plan. They are:

1. The woman alcoholic and alcohol abuser
2. Transportation needs
3. Youth and alcohol
4. Education

1. The woman alcoholic and alcohol abuser

As identified in the charts page 6-3 (analysis of sexes), the woman alcoholic and alcohol abuser is not receiving services in alcoholism which she could but will in the future. The age old myths concerning the moral values of the alcoholic are much more noticeable with the female than with the male. In the past due to lack of proper personnel, the professional alcoholism service providers have not had the opportunity to deliver a total comprehensive service to this special need area: With the proper funds, these services can be delivered. The work in this special need area at the present is being attempted by understaffed and underfunded programs.

The female "social drinker" does not have the openness in "social drinking" as does the male "social drinker". This social attitude is gradually changing. In the meantime due to age old myths of social and moral disgrace concerning alcoholism, the woman alcoholic is being identified more and more.

Pertaining to the comprehensive alcoholism service in this special need area, early identification of alcohol abuse and intervention prior to "hitting the bottom" can and will be offered.

2. Transportation Needs

In the past due to inappropriate funds, transportation costs for the alcoholic to emergency detox at the local hospitals has been neglected: Various businesses and agencies have been left with unpaid bills. Appropriate funds are included in this plan for this emergency service. Many times clients are referred to the State Alcoholism Treatment Center in Galen, Montana: A typical example for one trip from the Fort Belknap Reservation to Galen, Montana, is 654 miles round trip and 13 hours traveling time. This example is the longest of travel time and miles in Region II but does afford consideration to the transportation needs.

3. & 4. Youth & Alcohol, and Education

A basic approach to alcohol use and abuse in terms which can be understood by our youth has to be looked upon as a priority. Awareness of the disease concept of Alcoholism followed through with healthy communication of the subject should be looked upon favorably. At the present time the recognized age of being an adult is 18 in the State of Montana: It could be possible too much emphasis is placed on this point rather than assessing the total youth alcohol problem. Again due to lack of proper personnel and the funds to support this personnel, the youth special need area has not been met as favorably as possible: A complete comprehensive Alcoholism service has to be available. From the authority of Alcoholism in the state in conjunction with the Superintendent of Public Instruction, a filtering process of needed curriculum for our education system would be desired.

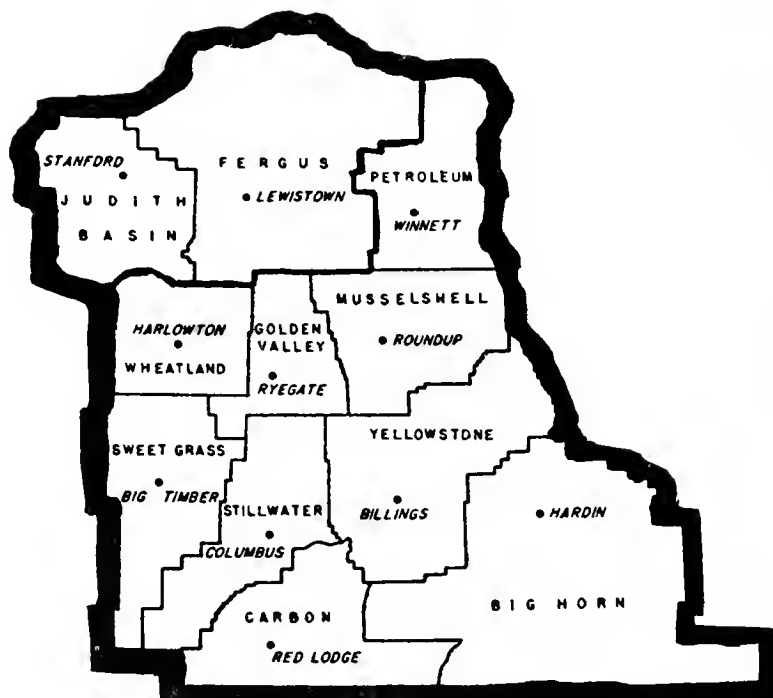
In the past, local Alcoholism Service providers have been attempting to work with the local school districts only to face barriers once the disease concept of alcoholism has been explained. Social stigmas of Alcoholism have played a key role in this area. (Refer to Charts "Analysis of Age", Page 6-4)

Affidavit of Publications for the nine county public hearings are on file at the Region II Addictive Resource Disease Specialist Office, Fort Benton, Montana. One public hearing was advertised and conducted in each of the counties in the nine county region ie; Blaine, Hill, Liberty, Toole, Glacier, Pondera, Teton, Chouteau and Cascade.

REGION III

ALCOHOLISM PLAN

1977-1978



Today, the vast majority of us welcome any new light that can be thrown on the alcoholic's mysterious and baffling malady. We welcome new and valuable knowledge whether it issues from a test tube, from a psychiatrist's couch, or from revealing social studies. We are glad of any kind of education that accurately informs the public and changes its age-old attitude toward the drunk.

More and more we regard all who labor in the total field of alcoholism as our companions on a march from darkness into light. We see that we can accomplish together what we could never accomplish in separation and in rivalry.

Bill

Co-founder of
Alcoholics Anonymous
From As Bill Sees It

INTRODUCTION

By administrative decision a regional approach to alcoholism services was initiated by the Montana State Department of Institutions in 1976 under authority granted to the Addictive Diseases Bureau of that Department by the State Legislature in Chapter 27 R.C.M. 1947. Five regions were established covering the entire State of Montana coterminous with the existing five Mental Health Regions. The plan that follows outlines previous services, resources, problem areas, needs and plans for alcoholism services in the 11 Counties of Region III for 1977-1978.

CHAPTER I

Demographics and Alcoholism Risk

Region III Demographics and Alcoholism Risk

Region III is composed of 11 Counties in South Central Montana with Billings, the largest regional city, as an economic and governmental service center. Table I lists the counties and population estimates for the region. If anything, these population estimates err on the conservative side due mainly to an economic and population growth rate accelerated by the development of stripable coal fields and associated activity in energy resource exploration and development. With the exception of the Billings area, the vast bulk of Region III is rural, sparsely populated, and characterized by small towns and an agricultural orientation. One significant and unique characteristic of the region is the location at the southeast rim of the region of the Crow and Cheyenne Indian Reservations. While some of the Cheyenne reservation does not specifically lie within Region III, for purposes of alcoholism services the Addictive Diseases Bureau has included state sponsored alcoholism activities on the Cheyenne lands within the purview of Region III alcoholism planning.

Population and Alcoholism Risk in Region III

Alcoholism is a serious health problem in Montana. The nature of medical reporting complicates the task of identifying the degree of severity. Alcoholism leads to other diseases and causes of death which, when reported, fail to specify the contribution of alcoholism to the disease or cause of death. Nevertheless, generally acknowledged methods

of estimating rates of alcoholism in given populations place Montana's alcoholism rate among the top three states in the Union. Using one method of estimating and given the alcohol consumption patterns in Montana and Region III approximately 8.5 per cent of the Region's population is a high alcoholism risk group. Using the 1975 estimate of population for Region III the number of alcoholics in the Region using this first method would be approximately 11,800. Using a second method which says that only 40 percent of a given U.S. Population ingests alcohol and that 10 percent of that drinking population will become alcoholics, Region III would have approximately 6,000 active alcoholics. Several factors present among demographic characteristics in Region III favor estimates based on the higher first method estimate over those based on the second or lower estimate. (See Table II)

Factors Influencing Alcoholism Rate in Region III

Alcohol consumption patterns in Montana and Region III indicate that more than 40 percent of the population consumes alcoholic beverages. There is a commonly accepted relation between alcohol and accidents of all kinds. National estimates disclose that between 50 and 60 percent of all accidents including traffic accidents are alcohol related. In 1976 the South Central Regional Health Planning Council made the following observations regarding accidental deaths in Region III.

The percentage of deaths by accidents is considerably higher in Montana and in the South Central area than experienced nationally. 5.3% of all deaths in the U.S. were caused by accidents compared with 8.5% for Montana and 9.0% for the South Central Region.

....In actual numbers, the 3 leading causes of death are heart disease, cancer, and stroke. Heart disease and stroke, and to a lesser extent cancer, are diseases of the aged. When life years lost and especially when working years lost are considered, the effect of death due to accidents becomes increasingly important in terms of productive years lost.¹

It is notable that the death rate from heart disease, corrected for age, is reported to be twice as high in alcoholics than might be expected. Given the alcohol consumption patterns in Montana and Region III, alcoholism undoubtedly plays an important role in the heart disease pattern in the Region.²

The higher accidental death rates in Region III when viewed from the perspective of the role alcohol plays in accidental death points toward higher alcohol consumption patterns in the Region and, hence, higher alcoholism potential.

Moreover, the presence of two large concentrations of reservation Indians and a relatively large off-reservation Indian population in the Region are factors which influence acceptance of a higher alcoholism target population.

A recent study of alcoholism among Indian people in Montana as a high risk group for alcoholism put the matter this way:

Whether one talks with the Indian people themselves, with professionals in the alcoholism field, or with leaders of Indian groups, estimates of alcoholism or drinking problems among Indian populations seldom go below 70 percent of the population. A generally accepted figure is 80 percent. In Montana most professionals interviewed in this study estimate that 70 to 80 percent of off-reservation Indians have alcohol problems requiring some form of treatment.³

In Region III Yellowstone County has a significant proportion of the region's population (65% in 1970) and is largely urban (87% in 1970) compared to the other counties which together comprise only 35% of the population and are all 100% rural, except for Big Horn (73% rural) and Fergus (49% rural).

¹ South Central Montana Health System Plan, Vol. I., 1976, p. 45

² Dr. Ernest P. Noble, NIAAA Information Service, April 27, 1977, p.2.

³ Clint Grimes, Alcoholism and Montana Indian People -- Toward an Off-reservation Indian Solution, Addictive Diseases Bureau, pp. 4-5.

Another demographic statistic important for planning (especially for alcoholism emergency services) is the sparseness of the population. In the non-Yellowstone Counties there is an average of 2.08 people per square mile whereas in Yellowstone there are 33.07 people per square mile. In Region III there are two minorities of significant number -- Native Americans and Mexican Americans. In Yellowstone County and Big Horn County 1.2% (1,063 people) and 38.9% (3,917 people) of the 1970 population respectively were Native Americans compared to less than .8% in each of the other counties. In Yellowstone County 2.3% are Mexican Americans while there are less than 1.0% in the other counties. The 1970 census figures probably seriously under-represent the Indian population and, particularly so in off-reservation areas such as Yellowstone County. ⁴

⁴See Clint Grimes, Ibid. p. 1, and Profile of the Montana Native American, Office of the Governor, Helena, Montana, 1974, p.17.

TABLE I
POPULATION BY COUNTY
REGION III

1960 - 1985

County	1960 Census	1970 Census	1975 Census Estimate	1980 Projection	1985 Projection
Big Horn	10,007	10,057	10,900	12,340	12,970
Carbon	8,317	7,080	7,700	8,370	9,100
Fergus	14,018	12,611	12,800	11,810	12,800
Golden Valley	1,203	931	927*	920	915
Judith Basin	3,085	2,667	2,700	2,735	2,770
Musselshell	4,888	3,734	4,100	4,310	4,530
Petroleum	894	675	658*	640	628
Stillwater	5,526	4,632	5,300	5,710	6,150
Sweet Grass	3,290	2,980	2,900	2,825	2,750
Wheatland	3,026	2,529	2,300	2,100	1,920
Yellowstone	79,016	87,367	97,300	107,430	118,610

*Based on special census.

Sources: U.S. Census of the Population; projections by John Short and Associates, Salt Lake City, Utah.

TABLE II

MONTANA RANK

Among 50 States

On Alcohol Indicators

<u>Indicator</u>	<u>Rank</u>
Per Capita Sale of Legal Alcoholic Beverages (U.S. Gallons of Absolute Alcohol per Person 18 or Older)	17
Amount and per Capita Public Revenue from Alcohol Beverages	4
Reported Deaths due to Selected Alcohol-Related Causes (Computed as a Percentage of all Reported Deaths)	
Alcoholic Psychosis	2
Alcoholism	20
Cirrhosis of the Liver	17
FBI-Selected Arrest Information (Computed as a percentage of all Reported Arrests)	
Driving under Influence	29
Drunkenness	19
Liquor Laws	4
Disorderly Conduct	15

CHAPTER 2

Alcoholism Resources in Region III

Alcoholism Resources in Region III

The major Alcoholism Resources in Region III include the following: Alcoholics Anonymous, Rimrock Guidance Foundation, Crow Detox and Alcoholism Center, the Cheyenne Alcoholism Center, and, since March, 1977, Family Services Inc., in Lewistown and in certain areas the South Central Montana Regional Mental Health Center. The South Central Montana Mental Health Center includes a major facility in Billings and satellite centers either full or part time in 7 smaller communities within the region and is a referral source for alcoholism clients to be referred to and from. A voluntarily staffed Alcoholism Information Center exists on the campus of Eastern Montana State College. A research and demonstration project, Morningstar Incorporated, operates a drug and alcohol abuse training center for Indian people located on the campus of Rocky Mountain College. Since May of 1977 in cooperation with Rimrock Foundation, the Billings American Indian Center is operating a small alcoholism follow-up program at the Indian Center offices.

Delivery of Alcoholism Services in the Region

Rimrock Guidance Foundation is the major funded alcoholism services provider in Region III, other than for those persons with alcoholism complications requiring hospitalization or those with major psychiatric conditions in addition to a drinking problem. In the latter two situations, the South Central Montana Regional Mental Health Center is the major provider of alcoholism services in Region III. Rimrock offers a variety of services on a combination fee for services basis and through funding from United Way locally, State of Montana alcohol and drug abuse grants, federal funding from NIAAA and a federal corrections sytem fee for services contract. It operates on a budget from all sources of approximately \$400,000.00 per year. Along with the Alcoholism Receiving Center and Deaconess Hospital, with which it is affiliated, Rimrock received approximately \$148,000.00 of contracted

State monies during 1976-77. In addition, it is receiving other contracted state and federal funds through the South Central Montana Mental Health Center for provision of Regional Alcoholism Services in the amount of approximately \$24,000.00. Rimrock offers a variety of services in the Billings area and has, with state assistance and through contracts with SCMMHC embarked upon delivery of services throughout Region III. Following is a description of Rimrock's services:

1. Facilities: Alcoholism Receiving Center (10 beds)
923 North 29th Street

Halfway House (16 beds)
(Dormitory & Experimental Treatment Center)
923 North 29th Street

Cooperative House for Men (8 beds)
28 Burlington Avenue
2. Residential Services: Rimrock has developed a continuum of residential services from detoxification to three-quarter-way services; varying in the degree of supervision and intensity of treatment available.

3. Outpatient Services:

Components:

- A. Intake - screening and assessment of clients' needs, development of a treatment plan and referrals.
- B. Out-Patient Primary Care Program - A concentrated four week evening treatment program for the chemically dependent person and their spouse or concerned person (parent, friend, etc.) Operates five nights a week offering educational lectures, group therapy, individual and family counseling and required attendance at A.A. and Al-Anon meetings. Cost is \$100/week.
- C. Spouse and/or Concerned Person Out-Patient Program:
 - (1) Pre-intervention program involving:
Spouse Education Group once a week
Education Series; every Tuesday for four weeks
Al-Anon Meetings
Individual Counseling
 - (2) Intervention - preparing family for an intervention, and doing the intervention. This is a specific technique educating the family for a loving confrontation session with the chemically dependent. Cost is \$100.00 for total process.
- D. Concerned Person Program - in conjunction with In-Patient Program. For family members of residential patients.

- A. Four week program consisting of educational lectures, groups, individual and family sessions and Al-Anon attendance.
- B. In the last week of In-Patient Treatment there is a concentrated one week program for these family members. Cost is \$100.00 last week.
- E. Aftercare - developing and monitoring clients aftercare plans. At present we have two aftercare groups. They meet once a week. Cost is \$10.00.
- F. Follow-up - a follow-up form has been developed and along with the NIAAA Data System Form is being administered.

OTHER DRUGS:

A contract with the State has been negotiated (ca \$40,000/year) as a fee for service basis to offer treatment to persons dependent upon drugs other than alcohol. This program is similar to the alcohol program.

ACCESS TO TREATMENT:

Regular staffing is maintained from 8:00 a.m. to 10:00 p.m., six days a week. Emergency services are maintained at all other hours via the Alcoholism Receiving Center. Within the next two months, regular Sunday services (emphasis on family services) will be established.

4. SERVICES TO BUSINESS AND INDUSTRY:

A formal Management Assistance Program has been developed and presented to selected employers in the area. Follow-up efforts and negotiations with a number of local businesses are in progress.

5. SERVICES TO LEGAL SYSTEM:

DAS or Drug and Alcohol Schools for persons convicted on alcohol and drug related offenses, (see description of DAS under Regional Services) treatment for federal prisoners under contract.

6. REGIONAL SERVICES:

Drug and Alcohol Schools:

- A. In cooperation with local law enforcement officials, county and city court systems and the South Central Montana Mental Health Center and its Satellites, Rimrock has established Drug and Alcohol Schools in Harlowton, Big Timber, Roundup, Lewistown and Red Lodge. The core curriculum of these schools is aimed at the DWI offender. A member of the Rimrock staff and former law enforcement officer teaches the schools at all locations except Lewistown. In Lewistown, in cooperation

with the newly formed, local, independent alcoholism program a staff member trained at Rimrock is providing this DWI or DAS school.

The D.A.S. School has a twofold purpose. First, an effort is made to offer education to the defendants about their alcohol use and the laws that pertain to drinking. It's assumed that the general public knows very little about state and local laws that apply to drinking of alcoholic beverages.

To achieve this goal of educating the individual on court referral, the D.A.S. School provides seven hours of educational experience for each individual in the program. A combination of films, lectures and group interaction offers the individual brief but functional impressions on alcohol use and the law.

The second, but more important goal of the D.A.S. Program, is to identify individuals who may have an alcohol problem. On a twelve month basis the D.A.S. Program served nearly 200 people. Of those individuals, it's been found that nearly 70% have alcohol problems of one degree or another. With identification of the problem drinker, the individual will be shown alternatives and recommendations on what can be done about the problem. Each referral coming into the program is administered two diagnostic tests that are effective in identifying possible drinking problems. These tests are only part of a detailed evaluation and the expertise of the counselor is necessary in order to make a final summary of each individual. The schools have been effective in getting individuals and families into treatment.

B. Hospital Detoxification Training:

Rimrock Foundation has trained or is in the process of training the staffs of local hospitals in modern detoxification techniques at the following regional locations: Big Timber, Harlowton, Lewistown, Red Lodge and Columbus.

C. Regional Counseling:

Rimrock Foundation has supplied counseling services to clients on a fee for service basis throughout Region III with the exception of Hardin. This service has been only intermittent and in conjunction with referrals from the Mental Health Satellite Centers, court and private referrals within the region.

CROW ALCOHOLISM PROGRAM

Funded by an NIAAA Grant, the Crow alcoholism program includes a detoxification unit, Halfway House and outpatient services.

The services provided are primarily for on-reservation inhabitants of the Crow reservation tribe. In addition to the NIAAA Grant, the Crow program received contracted funding of \$10,000 from the State of Montana and an additional grant for client services and detoxification through special monies distributed by the Region III Mental Health Board, (\$2,953.00).

NORTHERN CHEYENNE PROGRAM

The Northern Cheyenne Alcoholism Program is an out-patient program funded by NIAAA primarily for residents on the Northern Cheyenne Reservation. The State of Montana has not made a direct contract with this program for funds during the years 1975-1976 or 1977. The Region III Mental Health Center did contract with Northern Cheyenne for direct services and detoxification in the amount of \$2,953.00 during 1977.

LEWISTOWN FAMILY SERVICES INC.

In cooperation with local interested citizens, the Addictive Diseases Bureau and Rimrock Foundation, an independent alcoholism program has been formed in Lewistown during the Spring of 1977. A Board of Directors has been formed and incorporation has taken place. This new program is operating a DWI school and limited out-patient counseling activities are underway. Two part-time staff members have been trained by Rimrock Foundation and it is the intention of the program to seek County and State alcoholism funding for a full-time program of out-patient services.

SOUTH CENTRAL MONTANA MENTAL HEALTH CENTER

Over the past year the Region III Mental Health Center has performed in two roles regarding alcoholism services in the region.

Under the administrative decision of the Department of Institutions the Mental Health Board for the region agreed to serve as a coordinating agency in alcoholism services. Under contract with the Addictive Diseases Bureau, it hired a Regional Addictive Diseases Resource Development Specialist (RADRDS) to coordinate alcohol and drug activities within Region III. In this coordinating capacity the Regional Mental Health Center also contracted with the state for disbursement of federal detoxification and decriminalization monies. These funds were (or are) being subcontracted for services to Rimrock Foundation, Crow Alcoholism Program, Cheyenne Alcoholism Program, Morningstar, Inc., and hospitals throughout Region III.

The second role played by the Region III Mental Health Center concerns diagnosis and in many cases treatment. This includes virtually all of the detoxification requiring hospitalization in Billings Deaconess Hospital (as distinguished from non-hospital detox in ARC); and many outpatient and intermediate services with persons suffering from psychiatric disorders, in addition to alcoholism, and referrals of clients suffering from alcoholism who came to the Center or Satellite Centers for mental health services. During FY 1976 the * Mental Health Center recorded 139 alcohol related diagnosis within its regional facilities. State funds contracted for by South Central Montana Mental Health Center during the past year for administration of the RADRDS program and subcontracted to alcohol service providers amounted to approximately \$70,000.00.

MORNINGSTAR, INC.

This Indian training program is a research and demonstration project funded by the National Institute for Drug Abuse. In its 1976 year-end report, Morningstar defined its role in the following fashion:

*See Page for percentage of SCMMHC client load.

To best define what Morningstar is, it may be better to define what Morningstar is not. Morningstar is not a "treatment" center. Although we bring people into our program and train them in the various areas of living skills, self-awareness, and decision making, we do not "treat" them for any symptoms of abuse or for any of the self-destructive behavior or behavior society deems unacceptable, but rather we provide training for these people so they may recognize the difference between the two types of behavior and the reasons for them. It is at this point of recognition they begin to learn to make a decision with which they are comfortable and one that best meets their needs now and their plans for their future life.

. . . Morningstar is a research and demonstration project. This means simply that Morningstar is funded not to provide direct services, but to seek an effective means of combatting Indian substance abuse, and to find a model that can be used by all alcohol and drug programs. This will help insure the various programs' survival by having a program that will achieve positive results in their efforts through the use of the Morningstar model. The basic service Morningstar provides to the Indian people is the results (sic) of the research and demonstration of our model and theory that indicate its degree of success.⁵

In its role as coordinator of services the Regional Mental Health Center has contracted with Morningstar to provide training on special Indian problems in the alcoholism field.

BILLINGS AMERICAN INDIAN COUNCIL

This council is a member of the consortium of urban Indian alliances serving off-reservation Indian people in Montana. In May of 1977 Rimrock Foundation agreed to cooperate with BAIC to fund an Indian counselor to conduct information and follow-up activities at the Council headquarters in Billings three nights each week. B.A.I.C. serves a population of off-reservation Indian people in the Billings area who have a high alcoholism rate. The total number of off-reservation Indian people is variously estimated at between 1000 and

⁵Morningstar, Inc. An Experiential Learning Community "Year End Report 9-1-75 to 8-30-76", pp. 8 - 9.

3000 people in the Billings area.

EASTERN MONTANA COLLEGE

At the request of the Administration of Eastern Montana College a volunteer group offers alcoholism information to students at scheduled times throughout the school week.

ALCOHOLICS ANONYMOUS:

The most ubiquitous alcoholism resource in the region is A.A. This strictly voluntary fellowship exists in some form in every county in the region and on both Indian reservations. In terms of numbers A.A. groups vary greatly from area to area within the region. Most areas report growth in numbers over the past two years. In Yellowstone County rapid growth in A.A. has been experienced in the past two years and in the past year particularly. The major growth appears to have occurred within the age group of 25 to 30 years. This rapid growth rate reflects similar growth in A.A. nationally. Moreover, the average age of A.A. members nationally continues to drop and this trend is apparent in Region III as well.

CHAPTER III

Problem Areas

Problem Areas for Delivery of Alcoholism Services in Region III

Rural Area Services: Delivery of alcoholism services in the rural areas of Region III has been vastly improved over the past year. These improvements include the employment of the rural "circuit rider" counselor by Rimrock, the establishment of the Drug and Alcohol Schools within the Court system of rural counties and the in-service training of rural hospital staff, part-time counseling services by the "circuit rider" counselor and the improvement of referral and outreach contacts in rural areas with this circuit rider approach.

The creation of Family Services Inc. in Lewistown with two trained part-time counselors, a DAS school and in-service hospital training has substantially improved the availability of services in Fergus and the adjoining counties of Judith Basin and Petroleum.

Nevertheless, serious gaps in both services and in specific geographical areas remain. Principal among the service gaps are local emergency counseling services, follow-up services, treatment transportation services and general alcoholism out-patient counseling. With the exception of Fergus County, which has commenced services through Family Services Inc., all the rural county areas in Region III have these service gaps at the present time.

Big Horn County has a special array of problems. At the present time, the Crow Alcoholism program is in operation but the service delivery mechanisms between off-reservation and reservation programs appear

not to exist. The major city and County seat, Hardin, is served by the Satellite Mental Health Center. No DWI, Drug and Alcohol School or inservice hospital training has been accomplished in the county, and no alcoholism counseling outside the reservation exists at all. Some training has been provided to the reservation alcoholism programs. Both the Crow and Cheyenne reservations are "dry" reservations and along with local consumption, Hardin is the major source for alcohol in Big Horn County and for many people from the Northern Cheyenne Reservation. The size of the problem of alcoholism in Big Horn County can be illustrated graphically with the following figures. (See Tables III and IV)

These figures show that the Crow alcohol program client intakes equalled 12 percent of the entire Crow reservation's population of Big Horn County. Moreover, both Galen, Rimrock-ARC and the Mental Health Center receive clients from Big Horn County, 9 at Galen in 1975 and 12 at Rimrock-ARC in 1977. A projection of 30 clients from Big Horn County to these two programs for 1978 is not unreasonable.

Table IV shows alcohol related arrest rates for Big Horn County by race. Hardin is the major source for alcohol for the populations of two "dry" reservations. It is also the major city in the county and is the major alcohol source for all races in the county. Table IV shows that the arrests for drunkenness in Big Horn County totaled 2121 in 1975. Big Horn County had 13 times more arrests for drunkenness than Yellowstone County and had a total population 10 times smaller than Yellowstone County. Moreover, of these 2,121 arrests, only one was a white offender and 2,119 were Indian and one was Mexican American.

TABLE III

Population of Crow Reservation	5,096 - 1977 est.
Population of Northern Cheyenne Reservation	2,730 - 1977 est.
Big Horn County population	10,900 - 1975 est.
Number of Client Intakes Crow Alcoholism Program 1976	610
Number of Client intakes Crow Alcoholism program 8 month period July, 1976 - February, 1977	304
Number of client intakes Northern Cheyenne program for two month period, Jan., Feb., 1977	70
Projected client intakes for Northern Cheyenne Alcoholism Program over 12 months	420
Projected client intakes at Galen Alcoholism Center from Big Horn County 1977 (Galen - 9 in 1975)	15
Projected client intakes at Rimrock-ARC from Big Horn County (based on 12 intakes 1977)	15

TABLE IV

BIG HORN COUNTY

ADULT & JUVENILE MISDEMEANOR ARRESTS
BY OFFENSE, RACE & SEX

1975

Calendar Year, 1975

	<u>Total</u>	<u>White</u>	<u>Negro</u>	<u>Mex.</u>	<u>Ind.</u>	<u>Other</u>	<u>Total</u>	<u>Male</u>	<u>Female</u>
Riotous Conduct	237	4	0	0	233	0	237	225	12
Disturbing the Peace	28	6	0	0	22	0	28	25	3
Drunk	2121	1	0	1	2119	0	2121	1787	334
Drunk Driving	42	23	0	2	16	1	42	40	2
Possession of Alcohol	501	3	0	2	496	0	501	344	157
Gambling	0	0	0	0	0	0	0	0	0
Traffic - Reckless	59	0	0	0	59	0	59	49	10
Drugs	2	0	0	2	0	0	2	2	0
GRAND TOTAL	2990	37	0	7	2945	1	2990	2472	518

Approximately half the population of Big Horn County is white and half Indian. Drunk driving arrests indicate that white arrests are higher, proportionately, than Indian arrests. But, for drunkenness, an Indian person is over 2,000 times more likely to be arrested than a white person in Big Horn County.

The number of arrests and the number of client intakes demonstrate dramatically the very substantial alcoholism problem in Big Horn County.

In the urban area of Region III some service gaps also exist. The Rimorck-ARC-MHC/complex of treatment facilities needs expansion and plans for a 40 bed treatment facility are in process. The half and three-quarter way houses need to be supplemented with a facility for recovering female alcoholics. The entire area of sub-groups within the urban population needs to be addressed with greater effort and resources. These groups include the elderly, Mexican American and off-reservation Indian people.

The urban area is reasonably well endowed with communications facilities which are regional in scope. An organized alcohol information program using media presentations needs to be undertaken in the urban area.

Since the population concentration around Billings is being augmented by an expanding economy and since Billings is a regional economic, health and government services center, plans for an Eastern Montana State operated alcoholism treatment facility should address these basic economic, service and population facts.

Another problem gaining in severity in the urban area since decriminalization of alcoholism is the so-called "revolving door" alcoholic. The

TABLE V

CLIENT INTAKE CHARACTERISTICS

(July - February, 1977)

ADMISSIONS	
Total Admissions	<u>Region III</u> 953
SEX	
Female	197
Male	756
AGE	
10-20 years	35
21-30 years	197
31-60 years	626
61 and over	95
Unknown	--
RACE	
White	511
Am. Indian	417
Other	15
Unknown	10
INCOME	
0 - \$3600	386
\$3600 - \$8500	196
\$8500 and above	135
Unknown	236
EMPLOYMENT	
Employed	239
Unemployed	517
Unknown	197

demands on the health delivery system generally and alcoholism services specifically of the "revolving door" alcoholic will soon have to be faced in Montana.

Alcoholism and Minorities

Region III has a very significant alcoholism rate among minority peoples. All indicators, law enforcement, observation, client intakes, point to this as a primary identifiable problem in the Region. Table V shows that in the eight-month period from July of 1976 to February of 1977, 43 percent of all client intakes in Region III were Indian people. This figure is high, of course, because of the inclusion of two Indian reservation alcoholism programs. However, off-reservation Indian clients also make up a disproportionately large share of intakes at the Rimrock-ARC-MHC/complex as well. Table VI shows a typical three-month average of the Indian client percentage at Rimrock-ARC in Billings in 1976.

TABLE VI

Client Intakes 1976

<u>Treatment Center</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>3 Mo. Average</u>
<u>RIMROCK - BILLINGS</u>				
White	37	49	48	45
American Indian	8	13	18	13
Other	3	2	9	2
Percent Indian	17%	20%	37%	22%
<u>ARC-BILLINGS-DETOX</u>				
White	45	47	47	46
American Indian	18	12	25	18
Other	2	1	2	2
Percent Indian	28%	20%	34%	27%

Number of Initial Contacts and Client Intakes

July 1976 - February 1977

REGION III

<u>Initial Contact Reported to Date</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>Total</u>
ARC - Billings*	10	20	48	34	—	—	—	—	112
Rimrock	87	101	121	103	86	68	53	72	691
Crow Agency	95	42	39	50	28	31	5	14	304
Northery Cheyenne**	—	—	—	—	—	—	50	20	70
TOTAL	192	163	208	187	114	99	108	106	1,177

Client Intakes

ARC - Billings	65	60	72	60	—	—	—	—	257
Rimrock	48	64	66	68	38	27	20	16	347
Crow Agency	—	39	12	59	—	56	48	60	274
Northern Cheyenne	—	—	—	—	—	28	36	11	75
TOTAL	113	163	150	187	38	111	104	87	953

*ARC - Billings combined with Rimrock after October 1976.

**Northern Cheyenne was in Region I until December 1976.

Table VII shows the general picture of client intakes from the region for an eight-month period during 1976 and early 1977. Mobility among Montana's Indian people between reservation and off-reservation locations is very high as a recent study indicates:

Conditions on the reservation -- unemployment, boredom, etc., and a desire to test and see the outside world probably account for this mobility. The reservation is, however, the only remaining territorial base for many of Montana's Indians. Whatever hardships exist there and however bleak the prospects there, relatives live there and these strong family ties and the ties to the land are compelling attachments among Montana's Indian people to these reservation bases. And, so, because of these twin desires -- to participate in the white culture and return to the only remaining land base of Indian culture -- there exists a high mobility between on and off-reservation locations for most of Montana's Indian people. ⁶

For a number of reasons Montana's Indian people are highly susceptible to alcoholism. Region III has a relatively large number of Indian people and the consequences for alcoholism services are apparent. The findings of a recent study on alcoholism among Montana Indian people are clearly pertinent to Region III planning:

Proposals for treatment of off-reservation Indian alcoholism must address the following four major factors:

1. Alcoholism among off-reservation Indians is rampant and of epidemic proportions in Montana. This situation is the product of two primary forces:
 - a. An institutionalized drinking pattern leading to physical adaptation, tolerance, and dependence upon alcohol.
 - b. A high susceptibility to alcoholism which the evidence suggests is produced by a complex of genetic factors.
2. Indian people live in and are affected by two cultures and treatment modalities are principally grounded in the white culture only. Treatment is effective, therefore,

⁶Grimes, Ibid, p.2

only in the occasional cases where an individual is willing to accept treatment within only one culture -- the white, non-Indian context.

3. Upon termination of treatment, Indian people return to a social and family situation where the institutionalized drinking pattern is a principal, dominating force with little or no reinforcement for sobriety.
4. Lacking understanding of the processes of adaptation to tolerance of, and dependence on alcohol, family and social groups perpetuate the cycle of alcoholism among those already treated for alcoholism, among the young abusers of alcohol, and among those untreated but active participants in the institutionalized drinking pattern. It is important to note that the origins for the institutionalized drinking pattern are several: poverty, boredom, feelings of hopelessness, exclusion, abandonment, the Indian concept of sharing, dependence on alcohol itself, the anxiety of trying to live in two cultures, and several others.⁷

In the urban area, law enforcement data give some indication of the alcohol problem (See Table VIII) among minorities. Indian arrests are high compared to the percentage of Indian people in the population. This is in line with the known information on alcoholism rates and predictable arrest rates among Indian people.

The law enforcement data also show that Mexican American people have a disproportionately high arrest rate for alcohol related arrests. A survey of Yellowstone County where the largest regional concentration of Mexican-American people exists, indicates no specific action on the part of alcoholism programs to address this minority group.

⁷Grimes, Ibid., pp. 38-39

YELLOWSTONE COUNTY
ADULT & JUVENILE MISDEMEANOR ARRESTS
BY OFFENSE, RACE & SEX
1975

	<u>White</u>	<u>Negro</u>	<u>Mex.</u>	<u>Ind.</u>	<u>Other</u>	<u>M</u>	<u>F</u>	<u>Total</u>
Riotous Conduct	21	3	1	1	0	26	0	26
Disturbing the Peace	270	16	35	72	2	315	80	395
Drunk	94	0	12	56	0	128	34	162
Drunk Driving	298	4	13	35	0	320	30	350
Posses. of Alcohol	64	2	6	5	0	58	19	77
Gambling	5	0	0	0	0	5	0	5
Traffic - Reckless	118	1	9	6	0	127	7	134
Drugs	144	2	9	3	0	142	16	158
TOTAL	1,014	28	85	178	2	1,121	186	1,307

CHAPTER IV.

Alcoholism Plan for Region III.

Alcoholism Plan for Region III

The passage of HB 627 by the 1977 Legislature signaled a substantial commitment by the State of Montana toward funding of Alcoholism programs. The nature of that commitment includes the following two important factors:

1. The funding source is based on liquor tax revenues derived from sales in each individual county.
2. A substantial portion of the revenue so derived is returned directly to the individual counties to be spent specifically for alcoholism services in those counties.

Throughout the hearings on HB 627 it was clear that the sponsor's and legislature's intent was to initiate local county-wide programs where possible with monitoring and control by the Addictive Diseases Bureau. Funds allocated to the Addictive Diseases Bureau directly can be used as supplementary funding to achieve quality services. This move to establish direct county funding of alcoholism services with supplemental funding from the State Alcoholism Authority has a long history of support by individuals specifically concerned with alcoholism in Montana.

Funding in Montana under the previous statutes and under H.B. 627 are portrayed by region in Table IX. The figures in Table XII are distributed to the individual counties on the basis of liquor tax revenues collected by the state from liquor sales in each county.

Table X shows the portion of revenues being expended by the State of Montana for operation of the Galen Facility, administration of the Addictive Diseases Bureau and available supplemental funds for alcoholism programs in the amount of \$1,016,102.00 in 1978 and \$1,160,358.00 in 1979.

(These Department of Revenue estimates should be examined with caution because the Legislature Fiscal Analyst has indicated that total revenues may be \$200,000.00 less than these figures anticipate.)

The Addictive Diseases Bureau and the Governor's Advisory Council on Alcoholism have agreed in principle that a substantial portion of the \$1.1 million Department of Institutions budgets in FY 1978 and FY 1979 should go to the creation of a state operated alcoholism treatment center (or centers) for eastern Montana. Data concerning the use of the Galen Center indicate that while it is a statewide Center disproportionate use of the Center is made by counties closer geographically. Data from eastern Montana and Region III specifically indicate that a state center in eastern Montana would benefit alcoholism clients from the region. Table XI shows that even with the substantial services provided by Rimrock-ARC regional residents go to the state operated Galen facility also. Table XII gives a county by county breakdown of the anticipated earmarked alcoholism funding in each Region III county.

FUNDS GENERATED BY HB627

TABLE XII
County Distribution

FY '78 & FY '79

REGION III COUNTIES

	<u>FY '78</u>	<u>FY '79</u>
Big Horn	\$ 10,922	\$ 11,466
Carbon	12,730	13,364
Fergus	16,250	17,059
Golden Valley	898	943
Judith Basin	3,370	3,538
Musselshell	6,133	6,438
Petroleum	550	577
Stillwater	6,845	7,186
Sweet Grass	5,655	5,937
Wheatland	4,879	5,121
Yellowstone	<u>157,821</u>	<u>165,677</u>
 TOTAL	 \$226,053	 \$237,306

Previous Funding		Funds Genrated by HB 627 Regional Distribution	
<u>FY 1977</u>		<u>FY 1978</u>	<u>FY 1979</u>
129,000	Region I	\$ 137,229	\$ 143,977
247,000	Region II	232,369	244,036
147,237	Region III	224,014	235,166
185,000	Region IV	297,870	312,698
111,000	Region V	268,004	281,325
\$819,237*	TOTAL	\$1,159,486	\$1,217,202

*Contracted funding to programs by the State was \$731,110

Table X

ADB Supplemental Funding

FY '78

Dept. of Insitiutions	\$ 2,194,426
Addictive Diseases Bureau	- 185,000
Galen	- 993,324
TOTAL	\$ <u>1,016,102</u>

FY '79

Depart.of Institutions	\$ 2,334,934
Addictive Diseases Bureau	- 190,000
Galen	- 984,576
TOTAL	\$ <u>1,160,358</u>

Table XI

ADMISSIONS TO GALEN STATE ALCOHOLISM CENTER

From Region III

	Calendar Year 1975	Calendar Year 1976
Big Horn	9	13
Carbon	9	12
Sweetgrass	1	2
Wheatland	6	4
Golden Valley	1	0
Musselshell	11	4
Yellowstone	128	239
Petroleum	0	0
Fergus	17	26
Judith Basin	2	2
Stillwater	0	7

Given the funding pattern for Region III, (outlined in Table X), the existing resources and the problems illustrated in the planning document, the following planning elements should be undertaken.

1. Rural County Alcoholism Services.

The effort here should be to eventually establish independent County Alcoholism programs in Wheatland, Musselshell, Sweet Grass, Stillwater and Carbon Counties. At the present time, in cooperation with the Rimrock Foundation and local mental health center professionals, local advisory groups have been formed in these counties and an initial presentation to the County Commissioners has been made by these groups and Rimrock Staff. The basic elements of the proposed program in these Counties include the following approach:

- (a) That the existing advisory groups plan to form non-profit corporations responsible for alcoholism services to contract with the County for alcoholism funds.
- (b) In the interval that the Counties contract with Rimrock to train locally recruited counselors to meet state alcoholism certification standards to conduct emergency counseling services, DAS schools and follow-up counseling. That the counties contract either with Rimrock or the local hospital for detoxification services and that the Counties contract with Rimrock to supply on a fee for service basis part-time clinical supervision of local counselors (until such time as local programs can become fully independent) and 28 day treatment services as required.

Fergus, Judith Basin and Petroleum Counties:

With the establishment of the Family Services Inc. Alcoholism Program in Lewistown, it makes geographical sense for this program to contract with both Petroleum and Judith Basin Counties as well as Fergus to provide alcoholism services. The Fergus County Hospital with the help of the Mental Health Center psychiatrist when employed or other local physicians can provide detoxification services. Non-hospital based residential treatment can be provided by Rimrock under a contractual system. Since the funding resources for both Judith Basin and Petroleum Counties are minimal, Family Services Inc. will have to be assisted by a state grant.

Golden Valley County:

Rimrock has established an educational program within the school system in this County. Rimrock will contract with the school system to assist this County with alcoholism services. State assistance to Rimrock will be required to provide assistance to this County.

2. Urban Area Services.

Within Yellowstone County and the urban Billings area the major funded alcoholism program resource is Rimrock Foundation except for those alcoholic persons requiring hospitalization and those with services of psychiatric disorders in addition to alcoholism. The major latter resource is the South Central Montana Regional Mental Health Center. Rimrock is a state certified alcoholism program providing, with Deaconess Hospital and the Mental Health Center, a full array of alcoholism services. Rimorck's non-hospital residential treatment facility will be shortly expanded to 40 beds.

The intention of Rimrock is to contract with Yellowstone County for the provision of alcoholism services to that County on a fee for service basis. The Mental Health Center will seek certification for those

alcoholism services rendered appropriately by them. The Center will also seek alcohol tax funds from Yellowstone County. However, several specific areas of planning in Yellowstone County need to be addressed.

(a) The Indian minority, both reservation and off-reservation, in Yellowstone County and the high percentage of Indian clients at Rimrock, argue for inclusion of services for this high risk population. In May of 1977 a small program in conjunction with Rimrock and with Rimrock funding was begun with the Billings American Indian Council. The Billings American Indian Council is sensitive to the need and made the initial request of Rimrock for the follow-up, drop-in program just begun. Surveying the situation in Yellowstone County, BAIC has addressed the problem with the following proposal:

PROJECT PLAN FOR ALCOHOLISM PROGRAM

The purpose of this project is to address the problems Indian people in the Billings Area encounter due to repeated use or addiction to alcohol. This will be accomplished through the establishment of a walk-in crisis center. The facility will be concerned with rehabilitation and will focus on counseling, AA meetings, membership, drop-in center (both day and night), attitude changes and alternatives to drinking behavior. It will utilize Indian concepts and treatment bases to treat the members of the walk-in center.

The uniqueness of this program is that it supplies a continuum of services to Indian people that are congruent with the Indian culture.

It resolves essentially around Indian and non-Indian relationship in the Billings area.

Indian people are reluctant to use or participate in Alcoholics Anonymous programs or community sponsored services because they don't or can't express themselves in front of other people. This problem is often mistaken as a sign of ignorance or poor attitude and often just adds to an already serious problem. Many Indians can't cope with this problem and eventually fade from these types of programs.

The main concern of this program is with the unmet needs of Indian alcoholics in our community. Every Indian family with an alcoholic member will feel the impact of this program.

PROGRAM OBJECTIVES:

- A. To provide a walk-in center to assist Indian alcoholics that are trying to quit drinking and assist them in maintaining sobriety.
- B. To establish nightly Indian group therapy sessions, patterned after AA which would maximize Indian involvement.
- C. To provide a place where Indian alcoholics can spend time and conversation with people dealing with their type of problem.
- D. To enhance family stability by providing family and individual involvement.
- E. To seek out and counsel Indian people reluctant to accept traditional forms of treatment for alcoholism.

TOTAL PERSONNEL COSTS:	46,230.
TOTAL TRAVEL	<u>9,780.</u>
TOTAL NON-PERSONNEL COSTS:	18,580.
TOTAL BUDGET:	<u>64,810.</u>

This BAIC proposal is included in this planning document as a clear expression by Indian people of their needs which data elsewhere in this document support. It is recommended that funding of a program such as that suggested be undertaken in Yellowstone County with cooperation by Rimrock, Yellowstone County, BAIC and the State of Montana.

WOMEN'S FACILITY: While a half-way and three-quarter way house exist in the urban area of Region III, no facility exists for female recovering alcoholics. Such a facility should be of the minimum supervision, three-quarter way house type.

One area which may need to be addressed is the Mexican-American population in Yellowstone County. Arrest data indicate alcohol problems among this minority group sufficient to explore and undertake, if necessary, a Spanish-language alcoholism information program.

A recent nationwide study has revealed that alcoholism among senior citizens may be a significant problem and which alcoholism programs should address. It is recommended that this population be addressed through research of the outreach type to determine if senior citizens are a target population in need of attention from alcoholism programs in Region III.

Alcoholism programs in Region III have had an initial meeting in May of 1977 to search for methods of cooperation in training, joint grant applications, transportation, information and administrative services. This initial meeting included Family Services Inc. of Lewistown, Crow Agency Program, Northern Cheyenne Program, Rimrock Foundation, Billings American Indian Council and Morningstar Inc., as well as the consultant performing the RADRDS function for Region III. It is clear that such regional program meetings are an important step in combining resources

and planning services delivery and should continue.

SOUTH CENTRAL MONTANA REGIONAL MENTAL HEALTH CENTER: As explained elsewhere in this document, the Regional Mental Health Center has performed two basic functions related to alcoholism services in Region III. The first function is screening, treatments as outlined previously and referral to alcoholism services of clients who have alcohol problems. These cases include admissions or referrals to hospitals, the Rimrock facility and, in rural areas particularly, to Alcoholics Anonymous. According to the client data produced by SCMRMHC during fiscal year 1976, 139 clients were diagnosed as having some form of alcoholism problem. According to SCMRMHC's approach, clients with alcohol problems were in the following categories during 1976:

<u>Primary Alcoholism</u>	<u>Secondary Alcoholism</u>	<u>Tertiary Alcoholism</u>	<u>Other</u>
81	49	6	3

These 139 clients occurred in 1976 in a total case load of mental health clients of 2389, and represented approximately 6 percent of the total mental health case load for that year.

The second function related to alcoholism services performed by SCMRMHC was coordination of alcoholism services under contract with the Department of Institutions.

It is recommended that the Regional Mental Health Center and its satellites continue in their health provider role to refer clients with alcoholism problems to appropriate alcoholism services.

3. Coordination of Alcoholism Services in Region III:

With the passage of HB 627 and the development of alcoholism services on a county-wide basis, coordination requirements of regional

services will change. Independent alcoholism programs will develop in Wheatland, Musselshell, Sweet Grass, Stillwater, Carbon and Big Horn Counties. Such independent programs now exist in Yellowstone and Fergus Counties. Petroleum and Judith Basin Counties can receive program services from Family Services Inc. from its Lewistown base if this program is assisted with state funding. Golden Valley can receive such assistance on a similar basis from Rimrock Foundation. Most of these developing County programs will seek direct supplemental state funding from the Addictive Diseases Bureau in addition to earmarked County funding for Alcoholism. Coordination and technical assistance to these programs can best be supplied directly by the State Addictive Diseases Bureau. As the programs get underway either on their own or with technical and contract assistance from Rimrock Foundation, there will be no need for a full time regional Coordinator for Region III alcoholism.

In terms of intra-region coordination of alcoholism services, it is recommended that each County have a representative designated by the County Commissioners to serve on a regional alcoholism board. This representative should be an active member of the County-wide alcoholism board. This regional board should include in its membership the Governor's designate from Region III to the Governor's Alcoholism Advisory Council. This board should assume the functions previously undertaken by the Region III Mental Health Board and, if the interests of coordination merit such action, the Regional Alcoholism Board should meet on a periodic basis with the Regional Mental Health Board.

REGION IV
ALCOHOLISM PLAN
1977 - 1978



SECTION I. INTRODUCTION

The twelve counties comprising Region IV contain the largest population of any of the five state regions. The region is second only to Region I in square miles of area encompassed. The region contains Galen State Hospital, the major state funded inpatient treatment unit for alcohol, as a major resource for the inpatient treatment of alcoholism. However, the provision of outpatient treatment and follow-up services has been sporadic and quite lacking for the area covered and the populousness of the region. Though services have been available in the urban areas of the region, the smaller communities have had little coverage due to time and distance factors that are inherent to the region.

During the latter part of 1975 and most of 1976 major changes have occurred affecting alcoholism services within the region. One new program has started, the major program has had a total change in administration and other programs have altered their funding and operating management. The need for coordination and cooperation between all alcoholism workers is imperative at this time.

Alcoholism and alcohol abuse produces a heavy toll of those citizens of our region afflicted by this disease. The loss of valuable human resources, potential taxation monies, and most importantly, the loss of human dignity experienced by these afflicted persons is a prime concern to aware citizenry located within the region. The need for a concerted and effective thrust by the five regions within the state is absolute and it is hoped that this regional plan will help implement this goal.

SECTION II. PURPOSE OF THE REGIONAL PLAN

The purpose of the regional plan is to provide overall direction for the ensuing years in the treatment of alcoholism and alcohol abuse. The

A. Pertinent Regional Information

Mental Health Region IV consists of twelve counties encompassing some 28,690 square miles. The 1975 estimated population for this region is 184,835 persons. The three largest counties by population also contain the major urban population of the region. These counties are Lewis & Clark with a population of 38,936, Silver Bow with a population of 42,922 and Gallatin County with a population of 42,755. The major urban population centers respectively for these counties are: Helena, Butte and Bozeman. The remaining counties located there-in are very sparse in population and are characterized by smaller towns and cities separated by a number of miles. During the summer and fall months, travel within the region is pleasant and relatively speedy. However during the winter months the mountainous country, in particular three mountain passes, make traveling difficult and quite hazardous and sometimes impossible concerning provision of services to all clientele. Small cities of less than 2,000 persons are scattered throughout the region.

B. Descriptive Statistics

Needs Assessment from a Statistical Viewpoint - A needs assessment for any provider of human services can be approached in a wide variety of ways from a statisticians point of view. Some of the alternatives include; survey approach, social indicators approach, historical approach, or any combination of these. In addition, there are specific methods within each approach which make the alternatives broaden to almost completely individualized methods of needs assessment.

Our approach was encouraged by the amount of social, economic and demographic data available, though limited by the time and

resources available to acquire data in specific areas. We therefore used the social indicators approach with some indicators coming from the historical approach.

Using this combination provided us with several things. First, since the data had already been gathered, it freed the time and resources which would have been spent in gathering the data for other purposes. Secondly, this data has been examined for accuracy and reliability, thus saving time of this effort. And thirdly, since the historical data already exists, it is relatively easy to compare the social indicators with the historical data and from these, make projections as to how the trends will continue.

POPULATION ESTIMATES

COUNTY	1970 CENSUS	1975 ESTIMATE	PROJECTED		
			1976	1977	1978
BEAVERHEAD	8,187	7,693	7,594	7,495	7,397
BROADWATER	2,526	2,805	2,861	2,917	2,972
DEER LODGE	15,602	14,128	13,833	13,538	13,244
GALLATIN	32,505	42,755	44,805	46,855	48,905
GRANITE	2,737	2,461	2,406	2,351	2,295
JEFFERSON	5,238	6,048	6,210	6,372	6,634
LEWIS & CLARK	33,281	38,936	40,067	41,198	42,329
MADISON	5,014	5,613	5,733	5,853	5,972
MEAGHER	2,122	2,188	2,201	2,214	2,228
PARK	11,197	11,038	12,206	12,374	12,542
POWELL	6,660	7,178	7,282	7,385	7,489
SILVER BOW	41,886	42,992	43,213	43,434	43,656
REGION IV	167,100	184,835	188,411	191,986	195,663

REGION IV MENTAL HEALTH INTAKES

MARITAL STATUS

Marital Status/Unit	Granite Hill	Jefferson	Lewis & Clark	Lincoln	Madison
Married	2	-	20	230	-
Never Married	4	2	19	229	3
Annulled	-	-	1	1	-
Divorced	-	-	1	61	1
Separated	1	-	1	19	-
Widowed	1	-	1	13	-
Unknown	-	-	-	2	1
	<u>8</u>	<u>2</u>	<u>43</u>	<u>555</u>	<u>1</u>
					<u>7</u>

EDUCATION

Education/Unit	Granite Hill	Jefferson	Lewis & Clark	Lincoln	Madison
None	-	-	3	-	-
Some Grade School	-	-	7	41	-
Completed Grade School	2	-	5	54	-
Some High School	3	-	8	86	2
Completed High School	-	-	9	166	2
Some College	-	2	6	88	3
Completed College	-	-	4	56	-
Graduate School	-	-	1	17	-
Bus./Tech. School	1	-	3	12	-
Special Education	-	-	-	7	-
Unknown	2	-	-	25	1
	<u>8</u>	<u>2</u>	<u>43</u>	<u>555</u>	<u>1</u>
					<u>7</u>

2. Data is for total intakes (including alcohol) and extends beyond the geographic area of the region, but does not include Galen Center.

REGION IV MENTAL HEALTH INTAKES

MARITAL STATUS

Marital Status/ Unit	Meagher	Missoula	Park	Powell	Ravalli	Sanders	Silver Bow
Married	2	1	84	11	1	-	201
Never Married	-	1	60	5	1	-	199
Annulled	-	-	1	-	-	1	-
Divorced	-	1	13	6	2	-	66
Separated	-	-	3	-	-	-	33
Widowed	-	-	4	-	-	-	14
Unknown	-	-	1	-	-	-	4
	<u>2</u>	<u>3</u>	<u>166</u>	<u>22</u>	<u>4</u>	<u>1</u>	<u>517</u>

EDUCATION

Education/Unit	Meagher	Missoula	Park	Powell	Ravalli	Sanders	Silver Bow
None	-	-	3	-	-	-	23
Some Grade School	-	-	23	1	-	-	63
Completed Grade School	-	1	7	2	-	1	51
Some High School	-	-	34	2	1	-	98
Completed High School	1	1	58	9	2	-	138
Some College	-	-	18	5	-	-	71
Completed College	1	1	8	1	-	-	20
Graduate School	-	-	3	-	-	-	-
Bus./Tech. School	-	-	5	1	1	-	28
Special Education	-	-	5	1	-	-	21
Unknown	-	-	2	-	-	-	4
	<u>2</u>	<u>3</u>	<u>166</u>	<u>22</u>	<u>4</u>	<u>1</u>	<u>517</u>

REGION IV MENTAL HEALTH INTAKES

MARITAL STATUS

Martial Status/ Unit	Beaver- head	Broad- water	Cascade	Deer Lodge	Flat- head	Gallatin	Glacier
Married	57	14	4	88	2	3	-
Never Married	28	8	2	78	-	6	1
Annulled	-	-	-	-	-	-	-
Divorced	4	1	5	30	-	-	-
Separated	9	3	-	14	-	1	-
Widowed	3	-	-	12	-	-	-
Unknown	1	-	-	1	-	-	-
	<u>102</u>	<u>26</u>	<u>11</u>	<u>223</u>	<u>2</u>	<u>10</u>	<u>1</u>

EDUCATION

Education/Unit	Beaver- Head	Broad- water	Cascade	Deer Lodge	Flat- head	Gallatin	Glacier
None	4	-	-	4	1	-	-
Some Grade School	9	3	-	21	1	-	-
Completed Grade School	4	-	1	22	-	-	-
Some High School	24	4	2	55	-	4	-
Completed High School	21	10	3	62	-	2	1
Some College	22	3	2	20	-	3	-
Completed College	5	3	3	6	-	-	-
Graduate School	5	1	-	-	-	-	-
Bus./Tech. School	4	1	-	4	-	1	-
Special Education	3	-	-	4	-	-	-
Unknown	1	1	-	25	-	-	-
	<u>102</u>	<u>26</u>	<u>11</u>	<u>223</u>	<u>2</u>	<u>10</u>	<u>1</u>

JANUARY 1, 1975 - DECEMBER 31, 1975

SOURCE - CRIME CONTROL DATA

	<u>DWI</u>	<u>DRUNK</u>	<u>POSSESSION OF ALCOHOL</u>
<u>Beaverhead County</u>	2	6	3
Dillon	26	0	19
<u>Gallatin County</u>	52	3	2
Bozeman	119	75	69
Three Forks	0	0	0
West Yellowstone	8	6	15
<u>Broadwater County</u>	34	5	17
<u>Deer Lodge County</u>	43	2	13
Anaconda	20	0	21
<u>Granite County</u>	-	-	-
Phillipsburg	12	0	3
Drummond	3	2	0
<u>Jefferson County</u>	22	0	3
Boulder	2	1	1
Whitehall	4	0	0
<u>Madison County</u>	9	0	6
Sheridan	6	0	0
<u>Meagher County</u>	0	0	0
White Sulphur Springs	0	1	0
<u>Park County</u>	8	0	0
Livingston	21	7	3
<u>Powell County</u>	24	4	5
Deer Lodge	17	15	21
<u>Silver Bow County</u>	39	13	2
Butte	120	305	12
<u>Lewis & Clark County</u>	61	7	13
Helena	129	147	63
East Helena	5	0	0
TOTAL	<u>786</u>	<u>599</u>	<u>291</u>

Note - County figures indicate Sheriffs Department
City Figures indicate Police

After examining the social, economic and health indicators, several were found to have changed significantly from a statistical viewpoint. These were all indicators which would appear to have a direct relationship upon greater needs for Alcoholism Services. These include:

- 1) 1975 Marriage Dissolutions were up 23% from 1974.
- 2) 1976 Medical Assistance was up 71% from 1971.
- 3) 1976 Aid to Dependent Children was up 24% from 1971.
- 4) Social Security Supplemental Income to the aged was up 28%.
- 5) Social Security Supplemental Income to the Disabled was up 86%.
- 6) Over 7% of the Region IV population was receiving public assistance.
- 7) Nearly 10% of the Region IV population was receiving public and non-public assistance.

C. Other Significant Information

Economic Overview

In an effort to give an overview of the economic future for Region IV for the year 1977, we contacted the Montana Department of Employment Security, the Chamber of Commerce, the Department of Commerce, the Department of Community Affairs.

The Employment Security Division in their recent report using a composite of the six leading indicators which are, employment, average weekly hours, total accessions, and lay-off's in manufacturing, building permits, and the average weekly initial unemployment insurance claims, show that the composite index (for the month of September using the total year of 1975 and the year 1976 up to the end of September) shows the slight upturn since there is a shortage of employment in the manufacturing and building permits area with the trend in lay-offs which surpass the previous year.

They show the labor market unemployment figures for the whole state as 6.7% however, Region IV shows an unemployment rate of 8.6%. The Anaconda-Butte area shows an unemployment rate of 10.7%, which is far above the national average. They also show that with the continued draw on the unemployment fund for the state of Montana, that the unemployment insurance area will be in trouble probably by February or March of next year.

The total view of Region IV economic picture shows a stable area in Jefferson County, Beaverhead County, Meagher County, Madison County primarily because these are agriculture counties. The unemployment picture does not change a great deal, however the remaining counties, i.e., Deer Lodge, Powell, Granite, Jefferson and Silver Bow are those which are somewhat dependent upon the Anaconda Copper Mining Company in Butte

and Anaconda. It has been shown in survey that Silver Bow, Deer Lodge, Powell and Granite are very dependent on this particular corporation and with the contracts for miner and smelter men due in 1977, we can look to the worst thing that might happen, which would be a strike³ and certainly lay-offs will be in order during this period. We also have the factor that in the past two years we have had open winters. During an open winter in this Region, employment and construction remains at a pretty even flow, however as anyone who has lived in the area realizes, this can not be depended on and if we have an ordinary winter, as is likely, the unemployment rate in this Region will soar as it has in the past.

In conclusion, the year 1977 with the contracts coming due, the change in operation of the Anaconda Copper Mining Company, the slowing of highway construction; the general economic outlook for this Region, according to the Employment Security Division is for a difficult year and we certainly think this will impact upon the Alcohol Abuse problems of the Region.

³ This occurred in July 1977.

D. Existing Resources

GALEN STATE HOSPITAL

The Galen State Hospital is located in Deer Lodge County, 13 miles from the city of Deer Lodge. The program is state operated and consists of a detoxification unit containing both full medical and supervised non-medical detoxification. After detoxification the client is evaluated and a treatment plan produced which gives the patient a choice between the 28 day inpatient alcohol treatment and rehabilitation program or the two to six month long term rehabilitation modality. Both the 28 day program and the long term modalities attempt to involve families in the treatment process and at the completion of treatment referral is made to community alcohol programs or other appropriate helping agencies. An aftercare modality is in place which provides for evaluation at 30 day, 90 day and one year time period after completion of treatment modalities. The longer time evaluations are not yet fully implemented but the planning for implementation is complete and will soon be under way.

POWELL COUNTY ALCOHOLISM CENTER

The Powell County Alcoholism Center is located at 309 Missouri Ave., Deer Lodge, Montana. Catchment area consists of Powell County proper. The program is staffed by a director/counselor, and a full time secretary. A local governing board is the responsible operating body. Funding is from state and local sources with a total budget of \$20,580. The Powell County program provides out-patient counseling, referral, information, and prevention and education services to the area. The 1975 population for Powell county is 7,178 persons.

ALCOHOLISM SERVICE OF DEER LODGE COUNTY

The Deer Lodge Alcoholism Services is located at 600 Oak St., the main floor of the Community Hospital in Anaconda, Montana. The governing

body is the board of county commissioners of Deer Lodge County. An active advisory board provides input to the county commissioners as desired. The program is funded by state and local fund with a total budget of \$23,691. The staff consists of one director/counselor, one alcoholism counselor, and one half time secretary. Catchment area for the program consists of Deer Lodge County having a 1975 estimated population of 14,128 persons. Services provided consists of out-patient counseling, information and referral, and education and prevention. Medical emergencies are treated at the Community Hospital if deemed necessary, however Galen State Hospital is primarily used for detoxification services.

NORTH AMERICAN INDIAN ALLIANCE - BUTTE

The Butte Indian program is located at 12 East Galena in Butte, Montana. The governing body is a board composed of local Indian people. The staff has consisted of a director, who also directs activities of the Indian center, two alcoholism counselors, and a half time secretary. Funding for the program is provided by a NIAAA Grant amounting to \$42,385 and is due to expire on September 30, 1977. Services provided by the Indian center are out-patient counseling, and information and referral, and follow-up care.

COMPREHENSIVE CARE CORPORATION OF SILVER BOW GENERAL HOSPITAL

Comprehensive Care will be located in the Silver Bow General Hospital located in Butte, Montana. Comprehensive Care is a private profit making corporation headquartered in California. Current planning indicated opening of a nine bed alcoholism unit on December 13, 1976. In mid January full capacity of eighteen beds will be operational for alcoholism detoxification and treatment. Staff will consist of a part time psychiatrist social worker, a master degree level alcoholism

therapist, a trained alcoholism counselor and adequate trained nurses to provide medical care. Admission to the treatment modality will be a standard admission procedures existing in Silver Bow General Hospital. The inpatient treatment modality consists of 21 days of counseling and education. Basic cost of this program is \$85.00⁴ per day plus other emergency medical needs that may arise. The main source of funding will be the fees charged by Comp-Care and indications are that private insurance and private individual payment will be the primary funding source. The follow-up plan for the Comp-Care is established and consists of once per month contact for one year following treatment. Also they plan to continue contact sporadically for up to two years to ascertain success rate. Comp-Care hopes to serve the entire region and possibly the entire state as a alternative to Galen State Hospital or out of state programs now utilized by patients within the state of Montana.⁵

FORT HARRISON VETERANS HOSPITAL

Fort Harrison is located on the western out skirts of Helena, Montana and is a V.A. Hospital available to qualified veterans of the state. The alcoholism unit has a capacity of 46 beds, with an average of 20 to 30 patients flowing through per month. Staff consists of one trained alcoholism counselor. Medical services are, of course, readily available for all patients. Services offered consists of a medical detoxification and up to two weeks stay in the alcoholism ward. One to one counseling, group counseling and one AA meeting per week are available for all patients.

⁴Cost is equalized and is the same for detoxification.

⁵Other private profit corporations have expressed interest in Billings and Great Falls for facilities.

BOYD ANDREW GUEST HOUSE

This is a private residence ⁶ located in Helena, Montana, and is primarily a house providing residence for five clients. One to one counseling, appropriate referral, and AA group meetings are available. Staff consists of one alcoholism counselor and one house manager. Funding is obtained from individual clientele, vocational rehabilitation, and other private sources.

ALCOHOLISM REHABILITATION ASSOCIATION OF SOUTHWESTERN MONTANA

On April 14, 1976, the Board of Directors of the Alcoholism Rehabilitation Association of Southwestern Montana voted to remove themselves as the Board of Directors of the corporation and agreed that the Board of Directors of the Southwest Montana Mental Health Center would become the Board of Directors of the ARA. This board, comprised of county commissioners from the various counties or their representatives, is the governing body of the ARA. In the middle of May an Addictive Disease coordinator was hired by the Mental Health Center and given the responsibility of developing comprehensive alcohol services within the catchment area. The Addictive Disease Coordinator would also act as the RADRDS for Region IV.

ARA is currently operating 5 out-patient treatment units located strategically throughout the region. Catchment area consists of 10 of the 12 counties located within Region IV. Funding for ARA consists of a NIAAA Federal Staffing Grant, State Funds, and local match. Total budgeted monies for the program is \$235,541.00.

REGIONAL ADMINISTRATIVE OFFICE

The direct administration of the alcohol program is housed in the

⁶This facility has now incorporated as a non-profit entity.

Helena Regional Offices. This consists of regional Addictive Disease Coordinator, a Data Processor, and one secretary. The Addictive Disease Coordinator has primary responsibility for direction of the alcohol program but provides consultation to mental health coordinators to enhance delivery of services to clientele. The data Processor and secretary are jointly utilized by alcohol services and mental health; fiscal analysis and book-keeping are provided for both units by regional mental health personnel.

HELENA ALCOHOLISM SERVICES

The Helena Alcoholism Services Unit is located in the Mental Health Center in Helena and is staffed by three trained alcoholism counselors. These three counselors provide service to Lewis & Clark, Broadwater and Jefferson counties. The estimated 1975 population of this area is approximately 47,789. Services provided include one to one counseling, group counseling and emergency medical de-tox services primarily through St. Peter's Hospital in Helena, though the local hospital in Townsend, Broadwater county may be utilized if necessary. These hospital's are used for emergency's only and the major resource for medical detoxification and inpatient treatment is the Galen State Hospital located at Galen, Montana 68 miles southwest of Helena. The Helena unit also provides family counseling and education and prevention services to local schools, agencies, civic groups and Montana State employees. The integration of Mental Health and Alcoholism services has been exceptional in the Helena office. Cross referral, consultation, education and a general team approach has been achieved. The combination of the unique abilities of the Mental Health personnel and the trained Alcohol counselors have enhanced the intervention and treatment services provided to both sets of clientele.

BUTTE ALCOHOLISM SERVICES

The Butte Alcoholism Services staff is housed in the Mental Health

Center in Butte, Montana. Two trained alcoholism counselors are currently on staff with active recruitment for an additional counselor in process. The Butte office has responsibility for provision of services to Silver Bow and Granite county, a population of approximately 45,453. Services provided are individual and group counseling, education and prevention services, emergency medical care and referral to inpatient treatment. Medical emergency and de-tox treatment is available via the Silver Bow General hospital or St. James Hospital located in Butte. The primary source of detoxification and inpatient treatment is the Galen State Hospital located 32 miles northwest of Butte. The integration of alcoholism and mental health services is progressing well within the Butte office. Cross referral and utilization of specific areas of expertise among all personnel is evident. The alcoholism counselors are actively working with the alcohol program personnel employed by the North American Indian Alliance located in Butte and also with the Deer Lodge County Alcohol program located in Anaconda. The cooperative work between alcohol programs and Mental Health is yielding high quality services for clientele within this catchment area.

DILLON FRONTIER HOUSE

Effective September 1, 1976, the Board of Directors of the Dillon Frontier House⁷ in Beaverhead County voted to come under the administrative direction of the Alcoholism Rehabilitation Association. Prior to this time the Frontier House had been a contract agency receiving partial salary monies from the ARA. Other funding sources were a state grant and some local monies. The Frontier House is located on the main floor of the old hospital in Dillon, Montana. It is currently operating as a sub-acute detoxification unit and halfway house for clientele from Beaverhead and Madison Counties. Estimated 1975 population for these counties is 13,306.

⁷Renamed Dillon Alcohol Services and performing out-patient functions only.

Maximum capacity is seven persons with five as the usual population. The staff consists of two trained alcoholism counselors and a secretary. Recruitment is now underway for another counselor. Services provided for both inpatient and outpatients include one to one and group counseling, and medical evaluation. Transitional living space is provided for alcoholics that have completed inpatient treatment. The Center also provides outreach educational and consultation services, family therapy and referral to the Galen State Hospital for inpatient services as deemed necessary by staff members. The communities are primarily rural, ranching and farming types, and distance and travel is a major factor in limiting service production. Dillon is located approximately 100 miles from the Galen State Hospital.

BOZEMAN PROBLEM DRINKING CENTER

The Problem Drinking Center is staffed by two trained alcohol counselors. Both counselors have a number of college credits with one individual in possession of a masters degree. The unit also has a full time secretary. Offices are located in the First National Bank Building in downtown Bozeman, and consists of two private offices and a group room. The catchment area of the unit is Gallatin County with a 1975 estimated population of 42,755 people. The major population center in the county is Bozeman, which is also the home of Montana State University. Services provided by the Center include one to one and group counseling, information and referral and emergency hospital detoxification is available through the Bozeman Deaconess Hospital. Those clients needing non-emergency detoxification and inpatient treatment are taken to Galen State Hospital located 110 miles to the northwest. This is time consuming for staff members and volunteer AA members are recruited if possible. The Bozeman Center also provides consultation and education services. The utilization of educational services is extremely high in the Bozeman area due to staff efforts in establishing relationships within the University community and also the entire school system. Consultation is

provided to both undergraduate and graduate students that are doing research on the problem of alcoholism within the immediate catchment area but also on a more global basis. The Bozeman Problem Drinking Center has a active DWI school in operation. Referrals are received from local Justices of the Peace and also from district courts as part of the sentencing procedure. The DWI school is also available to the Park County catchment area. Both staff members of the program are members of the Advisory Board for the Gallatin Council on health and drugs which provides a liaison to the multiple services available in Gallatin County.

LIVINGSTON ALCOHOL INFORMATION AND REFERRAL CENTER

The office in Livingston is staffed by two trained alcoholism counselors. The area of responsibility for this office consists of Park County and Meagher County. The total population estimated in 1975 of this catchment area is 14,228 persons. The office location is in downtown Livingston, physical facilities consists of two private offices, a secretarial area and a drop-in coffee room and group room facility. Services provided by the Center include one to one and group counseling, education and consultation services, emergency medical detoxification, and referral and transportation to the Galen State Hospital for long term detoxification and inpatient treatment. The distance to the Galen State Hospital is 135 miles and therefore emergency medical care is provided by the Livingston Memorial Hospital in Livingston if deemed necessary by treatment staff. The two staff members in Livingston have been hired since July 1, and have been exemplary in establishing credibility with other community agencies. Client referral and requests for consultation and education have been growing at a rapid pace. The alcoholism program works closely with the mental health unit in Livingston, though they are physically separate. Both alcohol and mental health personnel participate in joint staffings and training sessions and cross referral by

Community Support and Response to Alcoholism Treatment Units

All five Alcoholism Satellite Units under the administration of ARA have active citizen Advisory Boards. These boards are made up of a cross section of community leaders that have a demonstrated interest in the disease of alcoholism. The Advisory Boards provide information dissemination vehicles, so that the total community receives information concerning alcoholism services. Problem areas are identified by both staff and Board members with discussion and possible resolution jointly reached by these individual. All boards have a number of Alcoholic Anonymous representatives and this enhances the liaison with this self-help organization as a referral group in the follow-up procedures. All Advisory Board members have a standing, and occasionally, special invitation to attend the Governing Board meetings held monthly. The Advisory Board members are expected to give input to the Governing Board, specifically about their catchment areas, so that decisions concerning policy will be reached that have positive effects for the majority of the 12 county region.

E. SURVEY OF NEED

The current percentage of population that will contract the disease of alcoholism is 8.5% of the general population. This percentage is put forth by the National Institute for Alcohol Abuse and Alcoholism. In using this figure for our current population of 184,835, one arrives at a target population of 14,867 potential alcoholics or serious alcohol abusers. The 1975 estimated Indian population of the region is approximately 1,600. In using a conservative figure estimated by NIAAA, 50% of this population will suffer from alcoholism or have severe alcohol abuse problems, therefore a more accurate figure would be approximately 15,500 individuals

⁸ Steppingstone Alcoholism Program, furnishing detoxification and resident care has been added.

as potential clients for the alcoholism and alcohol abuse program. If one then projects that the ripple effect i.e., those persons that will be directly affected by the individual exhibiting the disease of alcoholism or severe alcohol abuse, the total amount of affected individuals within the Region IV catchment area is 93,000 persons. Consideration then must be given to the fact that there is a relationship between alcoholism and alcohol abuse and the quantity of alcoholic beverage consumed by a given population. At the present time Montana ranks fourth in the nation for per capita consumption of ethyl alcohol in all forms. Coupling this data, the assumption could be made that the above figures are indeed a conservative estimate and could possibly be increased to give a more accurate figure. Enclosed, note the statistical information from January 1, 1975, until December 31, 1975, indicating a county by county, city by city breakdown of the arrests for DWI, public drunkenness and possession of alcohol. These figures indicate a relatively large number of arrests for alcohol related misdemeanors, but again rationally considering the fact that a much larger percentage of people are not arrested for alcohol related crimes when alcohol is a precipitating factor. There is a need in the region for a concerted effort in the area of the drunken driver. As an interesting side light, it is noted that during this same period the arrest of an individual for public drunkenness was in reality not legal, in as much as the Uniform Act prohibited this action by law enforcement. Therefore, one of the needs within the region is to educate law enforcement concerning the legality of public drunkenness and also the development of alternatives to jail, in the form of treatment centers located strategically within the region, so that the drunk individual may be medically evaluated. Another evaluation would be made concerning

need and type of treatment and appropriateness for that individual. This effort has been begun during the latter part of 1976, but needs to be continued during 1977 and 1978 to meet the needs of the inebriated individual within our communities. This need can be most effectively met by establishing medical and non-medical detoxification units within the region and by acquisition of more highly trained staff members to provide effective evaluation, education and prevention thrusts, and work toward a better public awareness of the problem of alcoholism within our communities.

V. REGION ALCOHOL ABUSE AND ALCOHOLISM COMPREHENSIVE ACTION PLAN

Goal 1. To provide adequate, trained personnel to provide all services needed by target population by September 1, 1977.

Objective 1.1 - A.R.A. will hire, six Masters Degree Level or equivalent addictive disease counselors to be placed in the various satellites as team leaders.

Objective 1.2 - Hire a trained alcoholism counselor for the Powell County Alcoholism Center.

Objective 1.3 - Provide training in family therapy to all alcohol program staff utilizing regional resource persons.

Objective 1.4 - To give inservice training on the disease of alcoholism to all mental health personnel.

Objective 1.5 - To add one trained alcoholism counselor in Butte and Helena satellites, as client load increases over 100 clients.

Objective 1.6 - To use $\frac{1}{2}$ FTE alcohol counselor in prevention and education services within various catchment areas.

Goal 2. Provide effective follow-up for post detoxification clientele.

Objective 2.1 - Will establish three Transitional Living homes in Butte, Bozeman and Helena, for persons completing detoxification and/or inpatient treatment.

Objective 2.2 - Recruit and hire appropriate staff for Transitional Homes in Butte, Helena and Bozeman.

Objective 2.3 - Reduce recidivism by 15% among alcoholics by providing Transitional home re-entry counseling in areas of vocational counseling and training, maintenance of independent living and alternative life styles.

Goal 3. Reduce by 25%,⁹ the number of repeating DWI convicted drivers within Region IV.

Objective 3.1 - Establish DWI program in appropriate out-patient treatment units by September 11, 1977.

Objective 3.2 - Obtain contracts with proper State Agencies for technical assistance with DWI programs by September 1, 1977.

Objective 3.3 - Obtain cooperation from Judicial System in Region IV by presenting DWI program outline to the various Judges by September 1, 1977.

Objective 3.4 - Motivate into ongoing treatment those DWI clients that are evaluated to be alcoholics or have highly potential alcoholic behavior.

Objective 3.5 - Utilize DWI education personnel in $\frac{1}{2}$ time education and prevention work with emphasis on education system.

Goal 4. Provide uniformity in record keeping systems and in treatment policies and procedures for alcoholism treatment units within the Region.

Objective 4.1 - A.R.A. administration will produce a policies and procedures manual, using a "directives" format, that will be placed in each component of A.R.A. and be made available to other programs.

Objective 4.2 - Establish a quality assurance system using a check list to insure that personnel are aware of policies that produce maximum effectiveness.

⁹ Insufficient data probable to evaluate in short-term, prevention efforts could lower total incidence.

DETAILED BUDGET FOR REGION IV PLAN

Goal I

3 Counselors at \$14,332 =	\$42,996.00
3 Counselors at \$15,722 =	47,166.00
19% Fringe =	23,714.00
Relocation and Recruiting Expense =	1,474.00
3 Counselors at \$9,000 =	29,700.00
½ FTE Education and Prevention Specialist =	4,950.00
TOTAL	<u>\$150,000.00</u>

Goal II

Salaries	\$70,566.00
Fringe	13,407.00
Rent	24,600.00
Utilities	3,600.00
Food	17,350.00
Phone	1,225.00
Supplies	1,440.00
Contracted Service	3,000.00
Miscellaneous	2,312.00
Equipment	12,500.00
TOTAL	<u>\$150,000.00</u>

Goal III

7 - ½ FTE Salaries	\$31,577.00
Fringe	5,999.00
Materials	7,350.00
Supplies	5,074.00
TOTAL	<u>\$50,000.00</u>

Goal IV

Travel & Per Diem	\$ 1,900.00
Supplies	800.00
Communications	100.00
Equipment	200.00
TOTAL	<u>\$ 3,000.00</u>

BUDGET

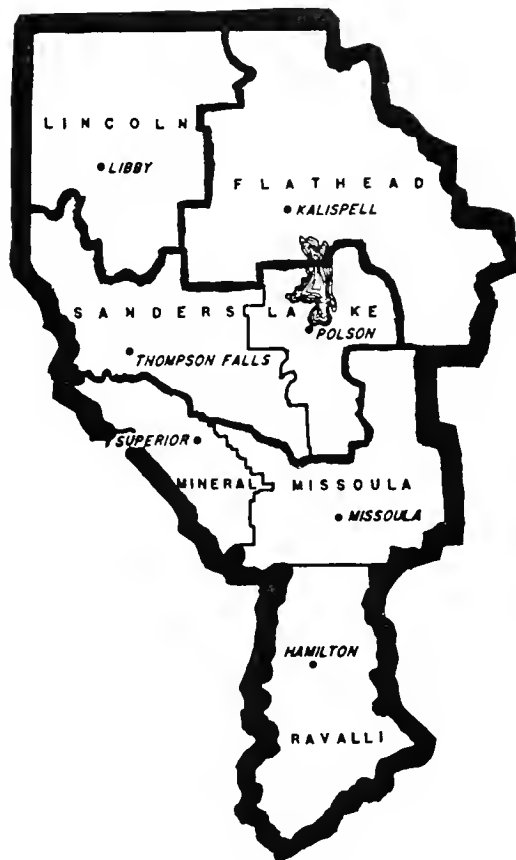
	Estimated Cost	
GOAL 1	\$150,000.00	
GOAL 2	150,000.00	
GOAL 3	50,000.00	
GOAL 4	<u>3,000.00</u>	
	\$353,000.00	
Current total budget for Region IV out-patient programs ¹⁰		\$322,197.00
Total needed to provide services		\$675,197.00

¹⁰ Does not include budget of Boyd's Guest House

REGION V

ALCOHOLISM PLAN

1977-1978



DESCRIPTION OF THE REGION

Geography and Transportation:

Montana, the fourth largest state in the nation, has a total area of 145,587 square miles. It is divided into an eastern and western region by the Continental Divide formed by the Rocky Mountains. One-third of the state is west of the Divide. The more than twenty five mountain ranges of Western Montana are heavily forested with valleys ten to twenty miles and twenty-five to a hundred miles long. Major streams flow through these valleys.

A major portion of Western Montana is included in Region V which encompasses Lincoln, Sanders, Flathead, Lake, Mineral, Missoula and Ravalli Counties. All of these counties are influenced by Pacific maritime weather patterns twelve to twenty-four inches of annual precipitation. Temperatures vary widely, frequently falling below 0°F in winter and often reaching 100°F in summer. Because of its mountainous nature, snowfall is often heavy, but blizzards are rare.

Region V consists of 19,330 square miles, which is comparable in size to Vermont, Rhode Island, Connecticut, Washington, D.C., and Delaware combined, with 1,383 square miles left over. It is approximately one-half the size of Ohio or three times the size of Hawaii.

The geography and distribution of transportation routes are major factors in determining service and trade areas in Region V. The transportation routes in Montana converge on a few major passes crossing the Divide, with four of these routes passing through Missoula and two passing through Kalispell and Whitefish. Because of this, Missoula and Kalispell, approximately one hundred miles apart, are the two major trade areas in the western region. There are many smaller towns twenty to thirty miles apart, which provide only the basic necessities of a rural area, and other towns with populations of 5,000 or more which offer more comprehensive services and are thirty to fifty miles apart.

Commercial airlines, railroads and bus lines serve Western Montana. Many rural areas not along the major routes are limited to private transportation. Highways connecting the towns and cities of Region V are usually open for travel during winter months, but road conditions are frequently icy and hazardous. Many of the roads are not conducive to high speed driving.

Amtrak railroads service Kalispell and Missoula. Passenger trains are available in Missoula daily during the summer months, but schedules vary in the winter.

Both Missoula and Kalispell have commercial airports. In addition to commercial flights, Johnson-Bell Field in Missoula and Glacier International Airport in Kalispell offer charter flights, small plane service and air ambulance service, with the Missoula field also handling Forest Service flights and shuttle service to Great Falls. However, there are times in the winter when planes cannot land at these fields due to fog or snow storms.

Bus service is available year-around along the main transportation routes, both east to west and north to south.

Because western Montana is characterized by mountainous terrain, a scattered population and pronounced weather fluctuations, geographic accessibility is an important consideration in planning the distribution of services in Region V. (See attachment 5, page 38 - MAP - GEOGRAPHY AND TRANSPORTATION)

POPULATION PROFILE

Population Change

The 1970 Region V population was 154,691, twenty-two percent of the State population. This Region has a pattern of growth for at least forty years, unlike the population of eastern Montana which, for the most part, is decreasing in population. From 1960 to 1970, the

counties in Region V increasing were Lincoln (44%), Missoula (31%) Flathead (20%), Ravalli (17%) and Lake (10%). Sanders only increased 3% and Mineral decreased 2%. A major construction project (the Libby Dam) largely explained Lincoln's increase.

Age Distribution

Historically the greatest number of individuals in a population were the very young. In recent years the population pyramid shape has begun to approach a columnar shape, as there are fewer young people and more older people. The 1970 Region V age distribution resembles the 1970 United States pyramid. The current lower birth rate, the remnants of the post-war baby boom, and the lower birth rate during the Great Depression are reflected in the pinches and bulges of the Region V pyramid.

The percentage of persons sixty-five and older has increased in the last forty years in every county of Region V. In 1970, 9.5% of Region V was sixty five or older, slightly less than the national figure of 10%, but Ravalli, Lake and Sanders all had higher percentages (14.9%, 13.5% and 13.4% respectively.)¹

Spatial Distribution

Much of Region V is rural. Only in Missoula County do a majority of the people live in urban area (74.4%). Flathead and Lincoln also have urban populations (41.9% and 18.2% respectively). The remaining counties are classified as 100% rural in the 1970 census.²

Educational Attainment

The trend over the past thirty years in Region V has been an increase in the number of years of education, such that in 1970 the majority of the people in the Region had attained at least twelve years of schooling.³

¹ See Attachment 6, page 39 and attachment 7, page 40

² See Attachment 8, page 41

³ See Attachment 9, page 42

Ethnic Groups

the population of Region V is more than 97% white. The largest minority is Native American, accounting for 2.5% of the population. Five counties have less than 2% Native Americans, with only Lake and Sanders having a higher percentage (15% and 5% respectively). The majority of Lake and approximately one quarter of Sanders is Flathead Reservation land. Only 0.15% of the regional population is black, and all other minority groups combined equal 0.27% of the population.

PERCENT OF STATE POPULATION,
Region V
1930-1970

Year	Population of Region	Percent of State Population
1930	75,245	14.0
1940	96,720	17.2
1950	111,681	18.8
1960	128,541	19.0
1970	154,691	22.3

Source: General Population Characteristics, U.S. Census of Population, 1970, pp. 31-32.

PERCENT CHANGE OF POPULATION,
Region V
10-Year Intervals, 1930-1970

Time Period	Population		Percent Change
	Beginning of Period	End of Period	
1930-1940	75,245	96,720	28.5
1940-1950	96,720	111,681	15.5
1950-1960	111,681	128,541	15.1
1960-1970	128,541	154,691	20.3

Source: General Population Characteristics, U.S. Census of Population, 1970, pp. 31-32.

AGE DISTRIBUTION IN MONTANA,
PERCENT OF POPULATION 65 AND OLDER
1930 - 1970

County	1930	1940	1950	1960	1970
Flathead	6.5	7.2	8.7	11.4	10.4
Lake	4.0	6.8	10.0	13.3	13.5
Lincoln	5.4	7.4	8.2	7.2	5.5
Mineral	6.3	10.8	10.7	7.3	7.9
Missoula	5.8	6.8	8.4	9.1	7.7
Ravalli	7.8	8.3	10.8	14.6	14.9
Sanders	7.4	8.2	11.1	13.2	13.4

Source: Montana County Profiles, 1973. Department of Comprehensive Health Planning, Helena, Montana p. 43.

SPATIAL DISTRIBUTION OF POPULATION, Region V

County	Land Area (sq. mi.)	Population	Population (per sq.mi.)	Urban* Total	Percent of Population	Rural** Total	Percent of Population
Missoula	2,612	58,263	22.3	43,531	74.7	14,732	25.3
Flathead	5,137	39,460	7.7	16,527	41.9	22,933	58.1
Lincoln	3,714	18,063	4.9	3,286	18.2	14,777	81.8
Lake	1,494	14,445	9.7	—	—	14,455	100.0
Ravalli	2,382	14,409	6.0	—	—	14,409	100.0
Sanders	2,778	7,093	2.6	—	—	7,093	100.0
Mineral	1,222	2,958	2.4	—	—	2,958	100.0

*Urban: a. Places of 2,500 inhabitants or more incorporated as cities, villages, boroughs and towns

b. Unincorporated places of 2,500 inhabitants or more

**Rural: The population not classified as urban

Source: Table 9, Number of Inhabitants, 1970 Census of Population, 1970. U.S. Government Printing Office, Washington, D.C. p. 12.

EDUCATIONAL ATTAINMENT IN REGION V COUNTIES RANKED BY
LEVEL OF EDUCATION FROM LOWEST NUMBER OF YEARS TO HIGHEST

Males and Females, 25 years and older

1970

County	Under 5 yrs.		County	8 yrs. and Under		County	12 yrs. and Under		County	Over 12 yrs.	
	No.	%		No.	%		No.	%		No.	%
Lake	278	3.5	Sanders	1,201	29.5	Lincoln	7,699	84.5	Lincoln	1,414	15.5
Mineral	54	3.4	Ravalli	2,335	27.9	Sanders	3,316	81.3	Sanders	764	18.7
Sanders	121	3.0	Lincoln	2,424	26.6	Flathead	16,517	78.5	Flathead	4,524	21.5
Ravalli	223	2.7	Lake	2,100	26.4	Lake	6,245	78.4	Lake	1,723	22.9
Flathead	454	2.2	Flathead	5,458	25.9	Ravalli	6,453	77.1	Ravalli	1,912	22.9
Missoula	516	1.8	Mineral	304	19.1	Mineral	1,211	75.9	Mineral	385	24.1
Lincoln	162	1.8	Missoula	5,038	17.9	Missoula	18,242	64.7	Missoula	9,969	35.3
Montana	10,002	2.7	Montana	91,558	25.1	Montana	272,872	74.9	Montana	91,636	25.1

Source: General Social and Economic Characteristics, U.S. Census of the Population, 1970.
Table 120, pp. 201-204.

Economic Characteristics:

From 1950 to 1968 the primary industry in western Montana to expand its employment was manufacturing, which includes the wood products industry. The federal government also increased employment. Other industries (agriculture and railroads) decreased employment. Overall, employment in western Montana increased by 32% compared to a state increase of 11% and a national increase of 33%.

Between 1959 and 1969, the median family income in Region V increased in every county. The number of families below poverty level decreased. However, the per capita income level for every county in Region V in 1969 was below the national level and is projected to fall even further behind by 1980.

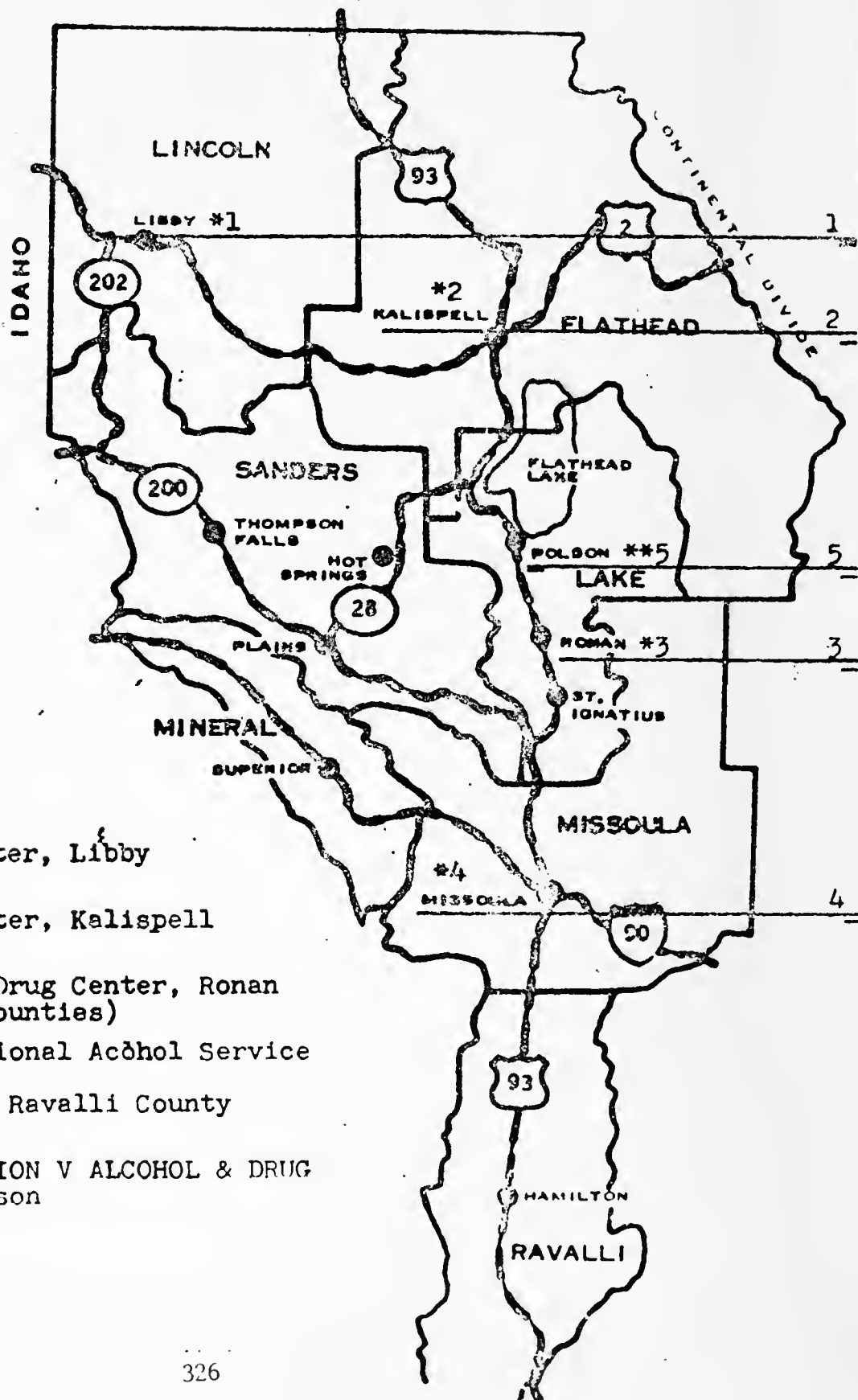
For selected industrial groups in Region V, the 1970 Montana County Profiles indicated manufacturing, including wood products, employed the largest percentage of male workers, while the Profile shows that retail trade employs the largest percentage of females.

In 1970, 8.6% of the labor force in Region V was unemployed. Toward the end of 1973 and during 1974, the national demand for housing dropped considerably. As a consequence the lumber mills in Region V have been forced to lay off workers for long periods of time. This, combined with other depressing effects raised unemployment in the Region. In November, 1974, the Missoula area experiences 10.9% unemployment (Missoula, Ravalli, Mineral and Sanders Counties), while the Flathead area experienced a 13.3% unemployment rate (Flathead, Lake and Lincoln Counties.)

Current statistics show Lincoln (Service Area 1) with 17.2% unemployment and a per capita income of \$3,897. Service Area 2, Flathead, has an unemployment rate of 12.1% and per capita income is at \$4,506. Service Area 3, Lake and Sanders have 7.8% and 8.8% unemployment respectively and per capita incomes of \$3,462 (Lake) and \$4,020 (Sanders).

In Service Area 3 figures show Missoula with 7.8% unemployment and per capita income at \$4,548; Ravalli with 11.7% unemployment and per capita income at \$3,369; and Mineral with 11.3% unemployment and a per capita income of \$3,785.

REGION V - WESTERN MONTANA



KEY:

- (1) Alcohol Service Center, Libby (Lincoln County)
- (2) Alcohol Service Center, Kalispell (Flathead County)
- (3) Flathead Alcohol & Drug Center, Ronan (Lake and Sanders Counties)
- (4) Western Montana Regional Alcohol Service Center, Missoula (Missoula, County - Ravalli County Mineral County)
- (5) WESTERN MONTANA REGION V ALCOHOL & DRUG COUNCIL OFFICE, Polson

REGION V ALCOHOL & DRUG ARRESTS

1975

	DRUNK				DRUNKEN DRIVING				POSSESSION OF ALCOHOL				DRUGS			
	T	F	M	U	T	F	M	U	T	F	M	U	T	F	M	U
Ravalli	11	0	8	3	50	0	48	2	2	0	0	2	21	7	10	4
Sanders	0	0	0	0	23	0	10	13	11	0	8	3	25	10	9	8
Mineral	0	0	0	0	9	0	9	0	0	0	0	0	15	13	1	1
Missoula	2	0	2	0	266	3	260	3	252	0	251	1	116	65	50	1
Lincoln	4	0	4	0	81	1	77	2	41	0	38	3	37	8	29	0
Flathead	56	1	14	41	139	1	31	107	51	0	16	35	60	26	16	18
Lake	89	0	74	15	132	1	128	3	41	0	34	7	5	0	4	1
TOTALS	162	1	102	59	700	6	563	131	398	0	347	51	279	129	119	31

Source: Montana Board of Crime Control, January 1 through December 31, 1975.

KEY: T - Total
F - Felony
M - Misdemeanor
U - Unknown

Alcohol Service Center, Libby, Montana

This program serves Lincoln County providing referral, outpatient counseling, education and prevention. They have been funded with \$9,894 from the Addictive Disease Bureau and \$3,900 from the City of Libby and Lincoln County, with additions of client fees. The major portion of their support is through temporary CETA funding.

Alcohol Service Center, Kalispell, Montana

This program serves Flathead County providing referral, outpatient counseling, education and prevention. The program also provides limited de-tox service upon referral from the Kalispell Hospital. They have been funded with \$50,569 from the Addictive Disease Bureau, \$10,000 from Flathead County in conjunction with two rent-free facilities and \$10,000 from the United Way, with the major portion of support through CETA funding. Recently Flathead County has provided this program with \$39,000 funding through the end of FY 76 to supplement discontinued CETA funding.⁴

Flathead Alcohol and Drug Abuse Program, Ronan, Montana

This program serves Lake and Sanders Counties from facilities at Ronan and provides services upon referral from other alcohol and drug programs. They also operate an Information and Referral service in Sanders County. A comprehensive range of service is offered which includes De-Tox, Intermediate Care, Counseling, Outreach, Follow-up, Prevention, Education, Information and Referral. Current plans are to construct a youth home. Sources of funding include Bureau of Addictive Diseases, IHS, NIAAA, and the Confederated Salish & Kootenai Tribes, totalling \$280,335.00.

⁴ Alternatives to this funding source are being explored.

Western Montana Regional Alcoholism Services, Inc., Missoula, Mont.

This program serves Missoula, Ravalli and Mineral Counties. Services are Information and Referral, Education and Counseling. Recently this program has expanded services to Ravalli and Mineral Counties under a Federal Incentive Grant. They have been funded with \$26,832.65 from the Addictive Disease Bureau, \$13,975 from Missoula County and \$22,915 of Federal Incentive monies.

Missoula Indian Alcohol and Drug Services

This program serves urban Indians within the City of Missoula. Services offered include Information, Referral and Counseling. The source of funding is NIAAA totalling \$64,000.

Missoula Employee Assistance Program, Missoula

This program provides assistance and referral to the employees of companies within the Missoula area. They have been funded by a federal grant of \$10,035 and \$9,099.96 from the Addictive Disease Bureau.⁵

⁵ Contract terminated by ADB.

NEEDS ASSESSMENT

The survey of need has established several areas of concern for alcohol abuse and alcoholism prevention, treatment and rehabilitation in Region V. The Action Plan section of this Regional Plan will develop these concerns, address itself to the implementation of programming dealing with these concerns and link them together since there are overlaps and relationships between them.

It is estimated that 8.5% of the non-Indian population in Region V are alcoholic. Based upon the 1970 census figure of 154,691, this shows that 13,149 residents are alcoholic. It is estimated that 50% of the Indian population in Region V are alcoholics which, based on the 1970 census figure of 3,397, indicates 1,969 alcoholic persons. These figures combined show that there are a total of 15,118 alcoholic persons in Region V. The number of others affected by alcoholism (family, employers, friends, relatives, debtors, etc.) is approximately 6. This figure indicates that 90,708 persons are directly affected by behaviors of alcohol abuse and alcoholism-----more than half the population of Region V.

The elderly represent an increasing proportion of our population in Region V. Because of the short winters and mild climate in many parts of this Region, a large increase of retired persons age 55 and over has occurred in the past decade. In 1976 the elderly population figure exceeded 10%, totalling more than 15,000 persons. According to a recent figure, 20 to 28% may be alcoholic. This shows a figure of 3,000 to 4,200 that may be seriously affected by alcohol. As the proportion of older persons increases in the years ahead, so will our need to understand and respond to the problem.

The aged who have drinking problems are likely to have health problems that complicate their situation. They are apt to face economic problems, difficulties associated with disengagement from the labor force and similar social relationships, bereavement, and other concerns that require considerable social and psychological adjustment.

However, evidence suggests that excessive drinking in the old is less associated with deep-seated psychological problems than it is in younger persons. "Rather, it appears more directly related to external factors concomitant with increasing age." ⁶

Thus, to the extent these external factors can be altered or the person enabled to deal with them in a less destructive way, the probability of success in treating the alcohol problem is relatively high.

An older person with a drinking problem faces two sets of related problems; one resulting from old age and the other from alcohol abuse. Indeed, these problems may have a synergistic quality with the resulting effect exceeding the sum of the parts.

One study found that older problem drinkers appeared to suffer from significant isolation, loneliness, and other psychological pain. The most important reasons for drinking were found to be those associated with coping and escape. ⁷

Just as the number of elderly is unevenly distributed among the nation's communities, so, too, is the older problem drinker. Some communities are made up entirely of retired, elderly people. As the proportion of the aged in our society increases over the next five decades (and as migration causes some areas to grow more rapidly), the situation will become even more acute.

⁶ "Alcohol Excess in Elderly" - Rosen and Glatt

⁷ "Life styles and Drinking Practices and Problems of Older Alcoholics" - Corruitt, Bruce, et al.

Community facilities are in short supply, there is an insufficiency of manpower and a lack of treatment know-how for problems specific to the elderly. Compounding the problem is a lack of personal resources or insurance benefits sufficient to secure available services to the aged. Frequently the problems and needs of these persons have been ignored by both service agencies and social analysts.

An indication of the lack of attention given the aging by mental health professionals shows that 60% of the elderly admitted to state mental hospitals had received no previous psychiatric care. This means the state hospital was the first mode of mental health intervention. This is an example of the delay to be expected in obtaining treatment for alcohol problems as well.

The older problem drinker may not interact with many other persons, in a job, or a social situation. The usual means whereby a younger drinker is identified -- work impairment, a driving arrest, or a family referral are less common among the elderly and treatment will be deferred.

Transportation to treatment, as with other health care needs of the elderly, may be difficult or impossible.

Older, retired problem drinkers are often regarded as poor treatment risks. Agencies may feel, consciously or not, that resources are better spent on younger problem drinkers for whom rehabilitation goals can be identified by a return to employment.

The number and proportion of older problem drinkers is small in comparison to other special-need populations. Even making allowances for methodological difficulties, we know that many older persons appear to restrict their use of beverage alcohol with advancing years.

Given the continued growth of the aged population in the next five decades and its redistribution through migration, some communities may encounter difficulties that require special assistance.

Older problem drinkers are over-represented in hospital populations ⁸ -- a fact that underscores the uniqueness of drinking problems (and their relationship to other health problems) for those older persons.

The older problem drinker differs from his younger counterpart in patterns of alcohol use, problems encountered through drinking, and even prospects for prompt recovery. Such differences need to be considered in any treatment program directed to older persons.

Total youth population, ages 12 through 19, in Region V is 25,905 (1970 census). There is an estimated target population of excessive drinkers in this age group of 6,547 (based on national average figures).

Alcohol use and misuse among teenagers has recently been the target of much media attention and national concern. Numerous stories have appeared in hundreds of publications and television news shows throughout the country on teenage alcoholism, alcohol as the "drug of choice" of young people, student drinking in school, and the impact of lowered drinking age on traffic accidents. This has resulted, on the one hand, in a panic similar to the drug scare of the early 70's, and on the other, in genuine concern among people in contact with youth to discover what is happening and what should be done about it.

In an effort to discover the nature of drinking behavior among adolescents, a national survey was taken by the Center for the Study of Social Behavior for the National Institute of Alcohol Abuse and Alcoholism.

⁸ Not apparent in alcohol treatment.

The final report of April, 1975, states that about 74% of the adolescent population (national probability sample of all Junior and Senior High School students in grades 7 through 12 in the contiguous 48 states and the District of Columbia) have had a drink more than two or three times in their lives. Of the adolescents surveyed, one half of whom are under 16 years of age, 54.8% drink once a month or more often and another 23.3 percent drink once a week or more often, with beer being the most frequently chosen beverage. On various scales to indicate problem drinking, the adolescents rank as follows:

Almost 1 out of 4 (24.1%) report having been drunk 4 or more times during the previous year. This frequency for drunkenness is 3 or 4 times greater than for all drinkers.

In reporting negative consequences of drinking, 17.1% of the youths mentioned difficulties with friends and 10.4% cited criticism from dates as a result of their drinking. Trouble with police was mentioned by 7% of the respondents and trouble with school personnel by 4.9%.

Forty percent of students reported drinking in cars and 15.9% reported driving after having had a "good bit to drink."

Thirty-five percent of the students said they drink alone at least sometimes.

Two and a half percent judged their drinking to be a "considerable" or "serious" problem while 9.8% stated they found their drinking to be a mild problem.

As in studies conducted at the local level, this national survey indicates that boys drink with greater frequency than girls and in greater quantity. However, there appears to be a noticeable shift toward more adolescent girls drinking alcoholic beverages than in previous samples.

As expected, the quantity and frequency of alcohol consumption increases with age. A dramatic shift between abstainer and drinker occurs from age 13-17.

White adolescents have the highest proportion of drinkers and Blacks the smallest proportion. Indian youth have the highest proportion of heavy drinkers (as defined in this survey, heavy drinkers drink at least once a week and 5-12 drinks per occasion) (16.5%), followed by Orientals (13.5%), Spanish (10.9%), Whites (10.7%), and Blacks (5.7%).

Drinking levels vary little by region of the country, and though some research indicates drinking levels vary inversely with urbanization levels, such differences did not show up significantly in the present study.

It should be noted that data does not include high school dropouts, studies indicate that the dropout population has a higher proportion of drinkers than the in-school population.⁹ The levels of alcohol consumption by teenagers is probably underestimated because of this.

Law enforcement statistics from the Board of Crime Control show that during 1975, 1,260 persons in Region V were arrested for offenses directly related to alcohol (DRunk, Driving While Intoxicated, and Possession of Alcohol). Local law enforcement officials indicate that, in their experience, the majority of all other offenses can be attributed to the misuse of alcohol in some degree.

Highway Patrol concern with the problem of the drinking driver is reflected in their basic training emphasis. Of thirty hours spent in training, eight hours (26%) are spent in areas relating to detecting and apprehending the drunk driver.

Highway Patrol records statewide show 3,600 Driving While Intoxicated citations. Region V accounted for 700 of these, or 19.5% of the total.

⁹ Source not available.

Statewide Patrol statistics indicate that 49% of all drivers killed in motor vehicle accidents were drinking. Of passengers killed, 34% had been drinking, as were 11% of pedestrians. This creates a statistical 40% of all persons involved in fatal accidents. The Region V percentage is significantly higher - 53%. (See attachment 11 - page 59, Highway Patrol Letter)

Region V had 21% of all motor vehicle accidents in the State of Montana - 4,042. A minimum of 12% of these can be attributed to drinking drivers (485 accidents). These accidents resulted in 2,143 injuries and 79 fatalities in the Region during 1975.

*Alcoholism is not a crime. It is an illness or disease which requires rehabilitation through a broad range of health and social services tailored to persons at different stages of alcohol abuse and alcoholism. The criminal law is not an appropriate device for preventing or controlling health problems. To deal with alcoholic persons as criminals because they appear in public when intoxicated is unproductive and wasteful of human resources.

*Present programs dealing with alcohol abuse and alcoholism are accorded a low priority and are unrelated to most of the health and social services within communities. Existing research as well as social, health, and rehabilitation laws and activities have not been effectively mobilized to solve the problems of alcohol abuse and alcoholism. These inadequacies have contributed to the inability of many private and public national, State and local institutions, agencies and organizations to recognize their responsibilities in meeting alcohol related problems.

*Too often the only community health resources for acutely intoxicated individuals is an emergency facility commonly known as a detoxification center. When isolated from other human services, these centers duplicate the "revolving door" syndrome long associated with repeated incarceration, rather than providing for the rehabilitation of alcohol abusers and alcoholic persons.

*Although many communities do provide some treatment facilities for persons with alcohol related problems, these services are frequently fragmented and fail to take into account either changing life styles or the unique characteristics of various population groups. Thus, alcohol abusers and alcoholic individuals may be deterred from seeking or accepting help in the communities where treatment should be readily accessible and designed for their specific needs.

*Faced with shortages of professional personnel and increasing demands for service, many alcoholism programs have demonstrated that ability to care for people is not restricted to any one profession. A variety of professional and trained para-professional persons, and trained members of such voluntary groups as Alcoholics Anonymous, can serve as effective providers of therapeutic and rehabilitative services.

*No battle against a public health problem can gain a significant victory if it attends only to the casualties. Appropriate treatment of persons who are abusing alcohol -- the primary condition that may lead to alcoholism---can lessen the development of many cases of alcoholism. Yet much of the work in the field of alcoholism has been focused on treating late-stage victims of the disease. Programs that are exclusively therapeutic or rehabilitative will not have long-term impact upon the problem, without prevention focus to decrease the incidence of alcoholism.

(*Alcohol and Health - Report from the Secretary of Health, Education and Welfare - 1975)

NEEDS FOR REGION V RANKED BY PRIORITIES

1. Stabilize the existing programs and expand permanent service to Ravalli, Mineral and Sanders Counties.
2. Primary treatment and De-Tox center in Missoula.
3. Detoxification services in Kalispell and Thompson Falls.
4. Transitional living facilities in Missoula and Kalispell areas.
5. System of follow-up after in-patient treatment.

Rationale Behind Priority Listing

As the Regional Advisory Council approached the task of discussing Regional needs, it became apparent that the needs were varied and multiple. However, it was necessary to approach those needs which seemed most feasible to short range goals in order to plan realistically for long-range goals.

Explanation of Priorities

1. Stabilize the existing programs and expand permanent services to Ravalli, Mineral and Sanders Counties.

Currently the Alcohol Service Centers in Libby and Kalispell depend largely on temporary CETA funding. These two programs are in financial stress due, mainly, to inadequate temporary funding. The need for additional funding is immediate and extremely important in order to continue the basic services in existence, insure stability and re-organize their structure.

Since the inception of the Regional Council it has become apparent that extending services to unserved counties held high priority. A portion of the Federal Incentive Grant monies were used to extend resource personnel into these three counties (Ravalli, Mineral and Sanders) on a part-time basis with expectations of developing permanent local support to insure continuation and continuity of services. However, because of the limited amount of dollars available, it is anticipated that additional funds will be needed in FY 77 to assist in continued efforts.

2. Primary treatment and de-tox center in Missoula

Currently these services do not exist, other than in limited form at St. Patrick's Hospital where alcohol and drug patients are treated in a ward generally used for treatment of mental disorders.

It is felt that a primary treatment center should be developed in conjunction with an acute and sub-acute de-tox facility, at a site yet to be determined, in the Missoula area. This is based on a large population and geographic location in the Region. Presently transportation of a client from Libby to Galen State Hospital is approximately 650 miles round trip. From Kalispell, approximately 450 miles and Missoula, approximately 200 miles. Citing the number of admissions into Galen State Hospital from Region V in FY 74-75 to October 14, 1976: (See attachment 12, page 62)

<u>COUNTY</u>	<u>#PATIENTS</u>	<u>MILES</u>	<u>\$ @ 15¢ per mile</u>
Lincoln	34	22,100	\$ 3,315
Flathead	120	24,000	3,600
Lake	39	5,850	877
Mineral	9	1,350	202
Missoula	135	27,000	4,050
Sanders	26	9,308	1,396
Ravalli	28	7,056	1,058
TOTALS	391	96,664	\$14,498

These figures do not take into consideration man hours involved, meal allowances, and in many cases, the cost of overnight lodging for those providing transportation and services. A conservative estimate for total costs of transportation, personnel, meal allowance and maintenance is approximately \$55,000. In addition, Missoula County has a population base of 58,263 (1970 census), which is approximately one third of the Region, and lacks drastically in services provided to the Alcoholic and Drug Abuser or Addict.

3. Detoxification services in Flathead and Sanders Counties.

Presently a sub-acute de-tox center in Kalispell provides services on a limited basis. This facility has been operative on a month to month basis due to inadequate funding. Efforts to initiate services for acute and sub-acute de-tox for Sanders County will be pursued with the hospital in the Plains area. To date, these services have been non-existent.

4. Transitional living facilities in Missoula and Kalispell areas.

In the past "Transitional Living Facilities: have been misconceived as a temporary stopping point or "Flop House" for inebriates and transients. The true definition is that of a client returning from primary treatment and halfway-from treatment back into society as a productive human being. These two facilities will be highly structures, highly disciplined with clearly defined goals and objectives for each client with a treatment plan designed by qualified staff. In addition, these facilities will be required to have a cross reference system with the primary treatment center.

5. System of follow-up after in-patient treatment.

The Region V Advisory Council feels that greater effort should be made throughout the Region to provide post-treatment care for the patient and family. This will be provided through the existing programs in the Region who will assume the responsibility of out-patient counseling, referring patients to mental health, welfare, vocational rehabilitation, employment, etc. Without proper follow-up to provide support, the significant effort in primary treatment will be wasted and contribute to the revolving door in primary treatment centers.

Needless to say, Montana is just beginning the embryonic stages of recognizing alcoholism and since passing H.B. 909 and the arrival of Mike Murray, Addictive Diseases Bureau Chief, significant positive changes have occurred. It is not just a matter of recognizing our needs, it is making significant progress once they are identified.

DEFINITIONS OF TERMINOLOGY

PRIMARY TREATMENT: Acute and Sub-Acute De-Tox

IN-PATIENT TREATMENT: Controlled environment for 30 to 45 days

TRANSITIONAL LIVING FACILITIES: Halfway House or semi-structured living facilities offering support during the transition from in-patient treatment to society.

PRIORITIES ADJUSTMENTS

During the review of the Regional Plan on November 30, 1976, the following priority adjustments were suggested by the program representatives.

PRIORITY #1: Primary Treatment (Acute and Sub-Acute De-Tox) in Kalispell, Missoula, Thompson Falls, Libby, and Hamilton

PRIORITY #2: Stabilization of local programs

PRIORITY #3: Transitional living facilities

PRIORITY #4: Follow-up

PRIORITY #5: In-Patient Treatment Facility in Missoula

Due to the lack of time with deadlines involved, budget adjustments and re-typing of the entire goals and objectives were virtually impossible to achieve.



**ALCOHOLISM AND MONTANA INDIAN PEOPLE
TOWARD AN OFF—RESERVATION SOLUTION**

by

Clint Grimes

A study prepared by

The Montana United Indian Association

Prepared for, and under a grant from

The Addictive Diseases Bureau

of the Montana State Department of Institutions

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INTRODUCTION

This study, prepared by the Montana United Indian Association under contract with the Addictive Diseases Bureau of the Montana State Department of Institutions, is an effort to approach what is obviously a serious state problem. Alcoholism among Montana's Indian people has reached a level demanding action based on a commitment by Indian people and by the State of Montana. This study outlines the extent of the problem and suggests courses of action to be taken. It is based on interviews with people knowledgeable about Montana's Indian people and about alcoholism. Indian people must solve the problem but they need assistance. The recommendations in the study outline the nature of that needed assistance.

Clint Grimes

Indian People of Montana

The mobility of Montana Indian people between reservations and off-reservation locations has always frustrated the efforts of census takers. The typical tendency has been to err on the conservative side in estimating Montana's Indian population. The 1970 census estimates Indian population in Montana as 27,130 for both on and off-reservation Indians. A more recent study (1974) done by Urban Management Corporation (UMC) under contract to the State of Montana estimates 36,710 on and off-reservation Indians in the state. UMC, using data from the census, Bureau of Indian Affairs and Montana United Indian Association, regards even this figure as a conservative estimate of Montana's total Indian population.¹

A more realistic estimate in 1977 would place the Montana Indian population at approximately 50,000. These people include those on seven reservations representing 14 major tribal groupings, and another loosely associated band called Landless Indians or alternately the Turtle Mountain Band and off-reservation Indians.

Regardless of the estimates used, the Indians of Montana represent the largest single minority group in the state. Approximately one out of every 20 Montana citizens is an Indian. More significantly, from the prospective of this report, there is high mobility of Indians within Montana between reservations, rural towns and other off-reservation cities. Job seeking accounts for most of the movement away from

¹ Profile of the Montana Native American, Office of the Governor, Helena, MT 1974, p. 17.

the economically deprived reservations to Montana cities. The result is that at any given time roughly half the state's Indian population is residing at locations away from the reservations with the major concentration of these off-reservation Indian peoples in the cities served by MUIA's Indian Alliance Centers. MUIA's eight alliances have documented the presence of 12,000 Indians living off reservations in the eight cities served by the alliances. The current director of the Federal Office of Native American Programs has indicated that the rate of movement away from reservations to cities is increasing nationwide and Montana is no exception.

Included among this off-reservation Indian population are the young, the job seekers, and in keeping with the cultural traditions of the Northern Plains Indian -- the old.

Conditions on the reservation -- unemployment, boredom, etc., and a desire to test and see the outside world probably account for this mobility. The reservation is, however, the only remaining territorial base for many of Montana's Indians. Whatever hardships exist there and however bleak the prospects there, relatives live there and these strong family ties and the ties to the land are compelling attachments among Montana's Indian people to these reservation bases. And, so, because of these twin desires -- to participate in the white culture and return to the only remaining land base of Indian culture -- there exists a high mobility between on and off-reservation locations for most of Montana's Indian people.

From the standpoint of white culture, there is a striking fact

about this Indian mobility, however. Montana Indian mobility has, in general, a very short geographical range. While mobility in white culture is characterized by wide dispersion of family, over thousands of miles, Montana Indian people generally confine their dispersions to a few hundred miles at most and usually remain in the state of Montana or among Indian groups near Montana's borders in Idaho and Wyoming. Families are very seldom separated by thousands of miles and spread across the continental United States as is commonly true of families in the white culture. For purposes of this study and specifically for comments on treatment approaches, this is a very important fact.

The Size of the Problem

Data bearing directly on the extent of alcoholism among Montana Indians is nonexistent. This state of affairs is not unusual due to the number of factors associated with accurate sampling of the disease characteristics of a given population. Even the data used for estimating alcoholism in the U. S. population lacks the necessary refinement of strict sampling tests and an estimate of a ten percent alcoholism rate in the national population is a gross estimate at best. Estimates of the rate of alcoholism among the U. S. Indian population have one characteristic in common -- they are very high. In Oregon, for instance, as reported by the Oregon Indian Commission on Alcohol and Drug Abuse,¹ more than eighty percent of all Indians over the age of fourteen abuse either alcohol or other drugs.

¹ 1975 State Plan on Alcohol and Drug Abuse; Oregon Indian Commission on Alcohol and Drug Abuse (Stewart L. Castro, Executive Director), 1975, P. 8.

The patterns of Indian alcoholism problems nationally was summed up in a statement before the Senate by Senator Edward Kennedy (D-Mass.): "The first area of concern, alcoholism, is probably the worst problem facing Indians." ¹ Shortly after the Kennedy speech, NIAAA Director Morris Chafetz, appearing before the Senate Committee on Alcoholism stated that . . .

" . . . alcoholism efforts have reached no more than twenty percent of the nation's Indians (and) it's completely unrealistic and primitive to assume that the needs of the Indians in alcoholism (have been met)." ²

Practitioners in the field of alcoholism also recognize the severity of the alcoholism problems among Native Americans as differentiated from other ethnic groups.

James Milam points out: . . .

" . . . It is estimated that some ten percent of all drinkers in the United States are alcoholics. However, the differential rates among ethnic groups are enormously varied, from a negligible rate below one percent for Jews, to something like eighty percent estimated for Indian and Eskimo groups." ³

Whether one talks with the Indian people themselves, with professionals in the alcoholism field, or with leaders of Indian groups, estimates of alcoholism or drinking problems among Indian populations seldom go below 70 percent of the population. A generally accepted figure is 80 percent. In Montana most professionals interviewed in

¹ JSL Reports; The Alcoholism Report: Newsletter for Professionals in the Field of Alcoholism: Vol. II, No. 13, April 26, 1974, P. 3

² JSL Reports; Ibid. P. 5

³ James R. Milam, Ph. D.; The Emergent Comprehensive Concept of Alcoholism, ACA Press, Alcoholism Center Assoc. Inc. P. 37

this study estimate that 70 to 80 percent of off-reservation Indians have alcohol problems requiring some form of treatment. The director of the Galen Alcoholism Treatment Center in Montana estimates that approximately 25 percent of the center's patients in any given year are Indian. This means that one of every four patients at the Montana Alcoholism Treatment Center is Indian. Yet only one of every twenty Montanan's is Indian. It is notable in this regard that while each of Montana's seven reservations has an alcoholism treatment center, the central Montana facility, Galen, continues to have a disproportionately high percentage of Indian people in treatment from what could be expected on the basis of probability alone; and Galen is not unique. All four of the off-reservation treatment centers in Montana have a disproportionately higher rate of Indian clients than real Indian numbers in the population would predict. Table I outlines this phenomenon in a typical three-month period during 1976.

The inordinately large percentage of Indian clients in these five off-reservation treatment centers is a substantial indicator of the seriousness of alcoholism as a disease among Montana's Indian population. The fact that Indian people in such numbers are undergoing treatment reflects a recognition on the part of Indian people themselves, the health professions, and the court system that alcoholism is extraordinarily severe among this unique cultural minority in Montana.

Admissions to Montana alcoholism treatment facilities are not

the only indicators of the severity of the disease of alcoholism among Montana Indians both on and off-reservations.

Alcoholic Indians suffer extensively from many chronic, even fatal, alcohol-related disorders such as cirrhosis of the liver, beer-drinker's heart, wine-drinker's stomach, and rampant infections of the mucous membranes of the mouth and nose. Other lesser-known ailments such as Wernicke's Disease, Korsakoff's Disease, and alcoholic Pellegra are also attributed to alcohol misuse among Indians.¹

In part, at least, the early age at death of Montana Indians could be traced to the physical deterioration consequent on both high rates of alcoholism and early age onset of alcoholism. The average age at death of American Indians nationally is 55 years of age. Tabel II shows that Montana Indians have a higher death rate at early ages than the national Indian averages. Montana's Aging Bureau has requested and received recognition of this early aging process and early death rate among Montana Indians. Several titles of the Social Security Act apply to Montana Indians beginning at age 45.

Moreover, professionals in the alcoholism treatment field in Montana have noted that alcoholism often occurs earlier among Indian people than among whites. This early age at onset of

¹ National Institute on Mental Health; Alcohol and Alcoholism: National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland, 1972, P. 10

TABLE I
CLIENT INTAKES 1976

<u>Treatment Center</u>	<u>July</u>	<u>Aug.</u>	<u>Sept.</u>	<u>3 Mo. Average</u>
<u>RIMROCK - BILLINGS</u>				
White	37	49	48	45
American Indian	8	13	18	13
Other	3	2	9	2
Percent Indian	17%	20%	37%	22%
<u>ARC-BILLINGS-DETOX</u>				
White	45	47	47	46
American Indian	18	12	25	18
Other	2	1	2	2
Percent Indian	28%	20%	34%	27%
<u>PROVIDENCE-GREAT FALLS</u>				
White	27	31	40	33
American Indian	7	12	7	9
Other	1	0	0	0
Percent Indian	20%	28%	15%	21%
<u>HILL-TOP</u>				
White	24	26	18	23
American Indian	8	6	4	6
Other	0	0	0	0
Percent Indian	25%	19%	18%	21%
<u>GALEN</u>				
White	121	119	136	125
American Indian	35	28	33	32
Other	3	2	1	2
Percent Indian	22%	19%	19%	20%

The Indian percentage of the total Montana population is approximately five percent.

TABLE II
AGE SPECIFIC DEATH RATES OF MONTANA INDIANS

<u>Age</u>	<u>Montana Indian Deaths (1972)</u>		<u>All U.S. Indian Deaths (1971)</u> *	
	<u>No.</u>	<u>Rate per 100,000 pop.</u>	<u>No.</u>	<u>Rate per 100,000 pop.</u>
Under 5 years	29	788.3	690	N/A
5 - 14 years	10	113.5	139	72.1
15 - 24 years	31	596.7	515	375.7
25 - 34 years	30	888.6	501	577.3
35 - 44 years	26	993.1	556	828.4
45 - 54 years	29	1527.9	631	1193.7
55 - 64 years	38	2800.3	720	1801.1
65 - 74 years	41	4270.8	798	3211.1
75 and over	42	9859.2	1018	N/A

* Includes all Indians living in the 24 states with Indian reservation services by Indian Health Service.

Source: Indian Health Service, Department of Health, Education, and Welfare, Washington, D.C.

alcoholism undoubtedly compounds the cycle of disease and accident related deaths that characterize the early age at death of Montana Indians. Table III shows admissions to the Galen State Hospital Alcoholism Treatment Center for a fairly typical two-month period in 1976. It is notable that the percentage of Indian patients in the younger age categories are considerably higher than comparable percentages for white patients.

The death rate profile contained in Table IV (which also includes Indians on Wyoming's Wind River Reservation), contains some pertinent data relating to the possible influence of a high alcoholism rate among Indians and high early death rates.

The accident categories in Table IV, for example, show substantially higher death rates among Montana and Wyoming Indians than rates for national or Montana populations as a whole. In the accident category alone, national estimates range from 50 to 60 percent of such accidents as being alcohol related. Extrapolated to these enormously high Indian accidental death rates, even the conservative 50 to 60 percent national alcohol relation accounts for a great number of Montana Indian deaths. It is very probable that the Montana Indians are five times more likely to die in an automobile accident than the average American. And, Montana Indians are over five times more likely to die of a homicide than the average Montanan. The true relation of alcohol to the Montana Indian accidental death rate is much higher than the 50 to 60 percent national relation.

TABLE III

AVERAGE AGE TABLE OF ALCOHOLISM ADMISSIONS FOR
OCTOBER AND NOVEMBER, 1976 - GALEN STATE HOSPITAL

<u>Age Group</u>	<u>(0-20)</u>	<u>(21-35)</u>	<u>(36-50)</u>	<u>(51-65)</u>	<u>(66-75)</u>	<u>(over 75)</u>
Indian Female		13	3	1		
Indian Male	2	23	19	8		
Total Indian	2	36	22	9		
Caucasian Female	1	10	11	9		
Caucasian Male	7	68	210	88	16	
Total Caucasian	8	78	221	97	16	
Age % of Indian Admissions	2.8	52.1	31.8	13.		
Age % of Caucasian Admissions	1.9	23.3	46.	19.8		

TABLE IV

SELECTED MORTALITY RATES OF MONTANA AND WYOMING INDIANS1970 - 1972Indian Deaths - Montana/Wyoming

	<u>1970 - 1972</u>		<u>All Races</u>	
	<u>Total</u>	<u>Rate per 100,000 pop.</u>	<u>U.S. 1972</u>	<u>Montana 1970</u>
Total Deaths	977	1014.2	942.2	950.0
Accidents	205	212.8	54.6	100.3
Motor Vehicle	(130)	(135.0)	(27.2)	(42.2)
All Other	(75)	(77.8)	(27.4)	(58.1)
Influenza and Pneumonia	49	50.9	29.4	31.8
Cirrhosis of Liver	45	46.7	15.7	14.1
Homicide	24	24.9	9.1	4.3
Suicide	32	33.2	11.7	11.3
Diabetes Mellitus	22	22.8	18.8	15.9
TB, All Form	7	7.3	2.2	1.7
Alcoholic Psychosis and Alcoholism	24	24.9	7.5	N/A

N/A - Not Available

Note: These figures represent statewide totals of all Indians, including those not residing in IHS service unit areas.

Population of 32,110 was used for 1970 - 1972 period.

Source: Indian Health Service, Billings Area Office; Bureau of Records and Statistics, Montana Department of Health and Environmental Sciences.

Table IV also indicates that the death rate among Indians due to cirrhosis is over three times higher than the national or Montana rate for all races. The relation of alcoholism to cirrhosis is a well established fact.

Morality rates in 1972, when data retrieval began, show Montana and Wyoming Indians over three times more likely to die of alcoholism and alcohol psychosis than people in the general U. S. population (See Table IV.)

Similarly, arrest rates for a selected group of off-reservation Montana cities indicate that the socio-legal consequences of Indian alcohol use are substantial in Montana cities. Table V shows misdemeanor alcohol-related arrests in the county seats of these counties and felony arrests in these cities. It is obvious from a comparison of the two tables that the Indian percentage of total arrests throughout the categories bears no relation to their real numbers in the population. An Indian is 30 times more likely to be arrested for drunkenness in Billings than population figures would predict. Undoubtedly, law enforcement practices account for part of this picture of high Indian arrest percentages, but even casual observation in these areas indicates that the level of arrests bear some real relation to alcohol-use patterns by Indians in these off-reservation cities.

TABLE V

MISDEMEANOR
ALCOHOL RELATED ARRESTS
JANUARY 1, 1975 THROUGH DECEMBER 31, 1975

	<u>Indians</u>	<u>Total</u>	<u>Percent</u>	<u>Indian % County Pop.</u>
<u>BILLINGS - Yellowstone County</u>				1.2
Disturbing the Peace	65	347	19%	
Theft	71	698	10%	
Drunk	56	160	35%	
Drunk Driving	32	306	10%	
Possession of Alcohol	<u>4</u>	<u>66</u>	<u>6%</u>	
Total All Arrests	334	2807	12%	
<u>GREAT FALLS - Cascade County</u>				1.8
Riotous Conduct	50	187	27%	
Drunk	116	253	46%	
Drunk Driving	<u>16</u>	<u>157</u>	<u>10%</u>	
Total All Arrests	554	2241	25%	
<u>HAVRE - Hill County</u>				9.3
Riotous Conduct	52	90	58%	
Disturbing the Peace	90	48	53%	
Theft	48	95	51%	
Drunk	62	87	71%	
Drunk Driving	16	89	20%	
Possession of Alcohol	<u>15</u>	<u>36</u>	<u>42%</u>	
Total All Arrests	409	1733	24%	

FELONY ARRESTS

<u>BILLINGS</u>	51	645	8%
<u>GREAT FALLS</u>	184	666	28%
<u>HAVRE</u>	17	61	28%

Recognition

Data in the preceding pages illustrate some of the health and socio-legal consequences of alcoholism among Montana Indians. Only by inference do they suggest the enormous cost in human suffering. Recognition of Indian drinking problems has become a racist cliché among non-Indians. Non-Indians, including the American Congress in the Indian Intercourse Act of 1832 have attempted to thwart Indian consumption of alcohol. States and counties have also attempted to restrict Indian drinking. These efforts by non-Indians have had two important consequences. First, they have not reduced Indian consumption of alcohol and second, they have reinforced Indian people's view that the white man is prepared to discriminate against the Indian on any pretext. Often these discriminatory acts by non-Indians, including public officials, are masked with good intentions when in reality they have another purpose. In 1977 in Montana, for example, the State Legislature's Chief Fiscal Analyst released a report on a proposal to sell wine in grocery stores. The report suggested that raising the drinking age of all Montanans and restricting sales of wine "around Indian reservations" could reduce the adverse social impact of the relationship between wine availability and alcoholism.

Great Falls Tribune, January 13, 1977

"The 1976 study showed that putting wine on grocery store shelves would lead to lower prices, greater accessibility, larger variety of brands, increased sales and no adverse impact on state government revenue.

The study said that those results could be expected to have a minor adverse social impact. It said there is a 'weak but positive' relationship between availability of wine and alcoholism.

But the study said that impact could be offset by raising the minimum drinking age and limiting wine sales around Indian reservations."

(emphasis added) Here the proposal for racial discrimination against Indians living near reservations is justified as reducing a "social impact" when in reality it is to increase state revenue from wine sales. Such efforts by non-Indians have met with little success and at best have been justifiably regarded by Indian people as discriminatory against Indians. Indian people have, themselves, recognized the alcoholism problem. In tracing the history of Indian drinking, Edward P. Dozier has noted:

"The prohibition of liquor by tribal councils on most Indian reservations after repeal of the federal law is indicative of the Indian's own concern about abuses in drinking. The Indians' attempt to eliminate drinking have also taken on more dramatic forms. One of the most important characteristics of American Indian nativistic movements, for example, has been the condemnation of drinking as the most evil and damaging introduction of the White man. Such well known nativistic and messianic movements as the Handsome Lake cult of the Iroquois, the Ghost Dance movement of the Western tribes and the Native American Indian Church all emphasize the evils of drinking. Where native aboriginal religion is still strong, as among the Pueblo Indians of New Mexico and Arizona, liquor is strictly forbidden for participants in ceremonial ritual. The individual Indian addicted to drinking has also sought various methods of eliminating the problem; he has immersed himself deeply in native religion, or frequently he has sought a "cure" by becoming a member of various Christian sects. It is thus clear that the Indian himself is very much concerned in solving the drinking problem." ¹

¹ Edward P. Dozier, University of Utah School of Alcohol Studies

In Montana both the Northern Cheyenne and the Crow Reservations have been "dry" since repeal of the 1832 act in 1953. From the standpoint of a realistic approach to Indian alcoholism, tribal agencies on Montana reservations have recognized alcoholism as a problem for some time. The Confederated Salish Kootenai Tribe, for example, has designated alcoholism as the reservations's number one problem and has committed substantial funding to create a very successful alcoholism treatment program.

In this study of the off-reservation alcoholism problem, one piece of existing research illustrates the sensitivity of off-reservation Indian people to the alcoholism problem. In a study conducted in cooperation with the University of Montana, the off-reservation Qua-qui Indian Alliance studied 141 Indian families residing in the Missoula area. Reflecting the mobility of Indian people in Montana, a majority of the heads of these families had lived in the Missoula area less than five years. Indians from all seven Montana reservations and the landless groups were represented in the survey. Over a third of these heads of families spoke an Indian language fluently with Flathead, Blackfeet and Cree being the most prominent. The heads of these households were asked to rank the most important problems facing them living off the reservation in Missoula County. The response is portrayed in Table VI.

TABLE VI

Ranked from most important to least important, what does the head of household think are the most important problems Native Americans face in Missoula County?

1. Employment
2. Alcoholism
3. Racial prejudice
4. Lack of education in schools
5. Housing
6. Lack of education
7. Other (i.e., transportation, lack of involvement in Indian programs, communication between people)

The results of this ranking of problems by Missoula's off-reservation Indians are notable in several respects. First, alcoholism is ranked second only to employment problems. A search for employment is the main reason for leaving the reservations in the first place. The documented relation between alcohol problems and employment problems is well known. Their voluntary ranking of alcoholism as second only to employment as a problem facing these off-reservation Indian people reflects a grasp of reality and an objectivity that alcoholism counselors might wish was present among the non-Indian population. Moreover, alcohol problems are ranked higher than problems of social dis-

crimination. Some Montana Indian leaders might regard ranking alcoholism problems above racial prejudice as an act selfless in the extreme on the part of these people.

While these data exist only for the off-reservation Indian population of the Missoula area at this time, interviews conducted in the course of this study indicate a substantial recognition of alcoholism problems in other Montana off-reservation areas as well. Similar surveys among Montana's other off-reservation Indian people would very likely produce similar, if not identical, results.

Alcohol and the Native American

Alcohol causes alcoholism. Why this fundamental fact is forgotten, ignored or suppressed in discussion of alcoholism generally, or concerning Indian alcoholism in particular defies rational explanation. Much of the writing, mainly from anthropological sources about Indian alcoholism, avoids this crucial causal relation completely. Avoiding this relation has produced an enormous volume of speculative and highly imaginative writing on the subject of Indian alcoholism. But since it avoids the fundamental relation between ingesting a toxicant and the subsequent physical and behavioral manifestations of the effects on the human system of that toxicant, this writing has virtually no value in treatment of the disease of alcoholism among Indian people (or any other people for that matter).

The core of the confusion in writing about Indian alcoholism

stems directly from confusion within much of the general writing on and practice of alcoholism research and treatment. The reform movement in alcoholism research and treatment signaled by the merger of the National Council on Alcoholism and the American Medical Society on Alcoholism in 1973 has yet to find its way into the writing on Indian alcoholism. This confusion and consequent inappropriate treatment of alcoholics has arisen from a variety of beliefs about alcoholism which both science and common sense reject. The alcoholism reform movement, while not directed exclusively to the problem of Indian alcoholism, provides those concerned with Indian alcoholism both renewed hope and a realistic basis for creating effective treatment programs. The alcoholism reform movement is an important and crucial corrective to widely-held views of the Indian alcoholic as morally degenerate, culturally inadequate, etc. Describing the reform movement, Milam points out:

"It is not uncommon in science for an impasse to be reached wherein data continues to accumulate, but integration is impossible until a deeply entrenched prevailing belief is finally challenged and superseded by a radically different premise. The field of alcoholism is at just such an impasse and the belief that must be overturned is none other than the most cherished certainty throughout history and in all the world today, the belief that alcoholism is caused by a symptom of a 'deeper' psychological problem. All manner of theological, cultural, and social correlates of alcoholism have been imbued with causative power and adduced in support of this psychological belief.

In earlier periods demon possession or moral degeneracy in the individual were invoked as causes of alcoholism. More recently the mental health professions have inherited the problem from the

clergy and the whole range of modern-day invectives, like 'personality inadequacy' and 'character defect', have been substituted for the earlier defamations. The semantics have changed, but the basic cultural belief has remained uncorrected that some elusive psychological peculiarity in the prealcoholic causes him to contract and progress in this most degenerate addictive disease." ¹

Some of the antropological writing on Indian drinking and alcoholism is squarely in the older mental health tradition of assuming psychological, behavioral and cultural correlates of alcoholism as somehow being causative. This mistaking of symptoms for causes in the mental health approach to alcoholism is rejected by the alcoholism reform movement:

"In sharp contrast to the mental health belief, the rationale of the alcoholism reform recognizes that both scientific evidence and clinical knowledge point the other way -- that the obvious and profound psychosocial symptoms of the alcoholic are secondary to his unique physical reaction to alcohol as a drug. Rather than denying the importance of psychosocial variables -- the increasing tendency toward excessive drinking, regressive immaturity, loss of personal integrity, addictive drinking, mental confusion, personality inadequacy, emotional disturbance, etc. -- the viewpoint of the reform actually stresses the seriousness of these symptoms by recognizing that they are rooted from the very first onset of symptoms in the progressively adaptive, toxic, and organic effects of alcohol." ²

Looked at from the viewpoint of the reform movement, much of the writing on Indian alcoholism and Indian alcoholic and drinking behavior needs serious modification. Modification of the older approaches to treatment of Indian alcoholism should begin with a

¹ Milam, Ibid. P. 2

² Milam, Ibid. P. 3

new look at the disease of alcoholism. For treatment to be of value to Indian people, the definition of alcoholism should be rooted in this reform movement. Milam states the definition at the core of the reform movement in this way:

"Alcoholism is a primary, progressively pathological, constitutional reaction to alcohol ingestion; psychosocial symptoms are secondary, derivative, and progressive regardless of premorbid psychosocial antecedents."¹

Using this definition of alcoholism suggests several questions concerning alcoholism among Montana's Indian people. As leaders in the reform movement have repeatedly pointed out, alcoholism is not the product of moral degeneracy. Two leaders in the movement, Drs. Seixas and Weisman, put it this way:

"We hope to effect a change in attitude among some medical practitioners. We shall attempt to show them that alcoholism is a respectable disease and not a moral weakness. This kind of attitude prevents some doctors from acquiring and using knowledge. The result is a needless loss of lives."²

The standard social stereotype of the shiftless, drunken Indian is widespread in Montana. So much so in fact that Indian people fear even clinical designation as alcoholics. This fear, reported in interviews conducted for this study, is a serious obstacle to treatment of Indian alcoholics. The widespread and mistaken notion that alcoholism is the product of moral weakness or insufficient will power is such a commonplace that both white

¹ Milam, Ibid. P. 3

² Milam, Ibid. P. 3

and Indian sufferers of the disease come to believe it themselves. And, while mental health approaches tend to dress up the charges in a more complicated language, the basic moral bias remains.

Indian Drinking Patterns and Alcoholism

Writing on Indian drinking habits is replete with descriptions of bizarre behavior produced among Indians by alcohol. Much of this writing misses a major point familiar to any alcoholism researcher or counselor -- alcohol often produces bizarre behavior among all living creatures ingesting it. The explanations of Indian drinking patterns fall into three major classifications. One major classification is the anxiety explanation. This explanation purports to explain Indian drinking in terms of socioeconomic deprivation and subsequent frustration. Another major classification incorporates a loose sociocultural, psychological explanation often including suggestions that alcohol is used by Indian people, in part at least, to assist in achieving religious experience. It is important to remember, however, that the reasons for drinking have little to do with alcoholism. As Dr. Milam points out:

"Potential alcoholics do not differ from non-alcoholics in their peer groups in any initial psychological, social, or cultural factors, and before symptoms develop they drink for all of the reasons other people do. To be sure, emotional stresses and social and cultural factors do influence the drinking rates of countless millions of drinkers." ¹

In a very perceptive review of drinking habits of the North American Indian, Dr. R. C. Dailey has pinpointed three distinct

¹ Milam, Ibid. P. 9

phases in the history of North American Indian drinking patterns. He calls these stages accommodation, deprivation and recreation. The accommodation stage started in the 17th century and was characterized by alcohol use for newly discovered methods of seeking religious or ecstatic experience. The deprivation phase began about 1830 with the relocation to uncongenial reservations and as Dailey puts it, alcohol was used . . .

" . . . no longer to seek, as they had formerly done, but as a means of escape."¹

Dailey's third phase, "recreation", he says, is similar to the first or "accommodation" phase and has the following characteristics:

Dailey's current or "recreation" phase:

1. Drinking remains a community-wide activity.
2. Getting drunk is highly valued and though an outlet for the release of aggressions, murders and serious maimings are not so numerous as before.
3. The object of drinking is gross intoxication.
4. Food and alcohol are seldom mixed.
5. Alcohol is always shared.
6. Little, if any, solitary drinking.
7. Moderation is practiced only by the most acculturated.
8. Drinking is noncompetitive and little, if any, value is placed on capacity.
9. No cultural controls to unbridled use.
10. There appears to be little shame or guilt associated with intoxication.

¹ R. C. Dailey, Ph. D. Alcohol and the North American Indian: Implication for the Management of Problems; Unpublished Paper, Univ. of Utah, School of Alcohol Studies

The drinking patterns of both on and off-reservation Montana Indian people incorporate many of the characteristics outlined in Dailey's "recreational" phase. It is notable, however, that while shame and guilt seem absent, interviews in this study and data reported elsewhere in this study indicate a very high level of concern over the results of the Montana Indian drinking pattern by Indian people themselves.

One ubiquitous feature of Montana's Indian drinking pattern is "sharing". (See Dailey's fifth characteristic.) Sharing is not confined to reservation drinking but is found wherever Montana Indians congregate to drink on or off the reservation. Money to purchase alcohol is donated by members of the group according to their ability to pay. This "Frisco circle" pattern of drinking is a feature of both young and old drinkers. It occurs on the two "dry" reservations, the other five "wet" ones, and in off-reservation locations as well. The "bootlegging" operation on Montana's two "dry" reservations is well known. Private individuals purchase liquor off-reservation in retail stores or bars and sell it at inflated prices at on-reservation locations. These purchases are frequently possible through the sharing or "frisco circle" type social drinking groups.

Many writers have commented on the "binge" drinking pattern of Indian people -- the periodic group drinking bouts described by Dozier as "gang" drinking. Sometimes these descriptions lead the writers to conclude that the Indian problem is drinking and

not alcoholism. Unfortunately, this deceptively simple analysis avoids the fundamental fact that alcohol causes alcoholism. Binge or periodic drinking when it does occur among Indian people is primarily a matter of economics -- not a cultural trait. The wide use of Sterno, mouthwash and low cost wines among both on and off-reservation Montana Indians who have reached the adaptive phase of alcoholism are testimony to the important part played by the availability of ready cash for drinking purposes. This state of affairs is quite typically found among non-Indian people whose physiological needs for alcohol have progressed. The inability of some observers to accurately deal with this periodic drinking pattern and its economic base is partly due to the physical nature of the effects of alcohol on the drinker. Thus this pattern of drinking often disguises what is really happening:

"The early onset of alcoholism usually goes unnoticed in drinking circles and undetected in professional practice for several reasons. Because of the gradual onset, and compared to the more familiar loss-of-control symptoms of more advanced alcoholism, early symptoms are easily rationalized and seem trivial to the individual and his associates. Professionals are typically trained to rationalize the symptoms, and thus participate in the patient's inverted thinking about cause and effect. Gradual compensatory adjustments often disguise differences in the individual's drinking from year to year or between his drinking and that of his companions at any point in time. The insidious physiological differences and changes are not detected in the early stages because the effects of both drinking and withdrawal are so disturbing to body chemistries that baseline differences are masked, and because when the acute effects subside the baseline differences between alcoholics and non-alcoholics are often too small to create interest or to show positive in ordinary clinical examinations. A very substantial amount of liver damage can be sustained

before it is detectable in liver function tests. Moreover, no clinical tests are available to measure many of the structural and functional changes in various organs and tissues." ¹

The pattern of Indian drinking has led some observers to speculate that periodic drinking produced by an absence of cash may regulate Indian drinking to such a degree that alcoholism is less likely to occur. Unfortunately, this view is contradicted by the evidence of more recent scientific findings on alcoholism and, in Montana, by the mounting evidence at alcoholism treatment centers throughout the state of alcoholism among Indian people. Even Dailey, who holds this regulatory view, says:

"The Indian in North America seems to be rapidly approaching a critical point in his drinking behavior. Not only are alcoholic beverages more readily available than ever before, but also the younger generation are drinking in a permissive atmosphere where alcohol has become their chief source of recreation. With nothing to do, drinking has become established as an end in itself." ²

It is the view of this study that Dailey's critical point is not "approaching" but has been passed in Montana. The institutionalized character of Indian drinking patterns in Montana has, of course, produced a pattern of drinking among younger Indians and even imitation of drunken behavior by very small children who are around adults exhibiting actual drunken behavior. As Percy DeWolf, former State Senator and member of Montana's Blackfeet Tribe has explained, "Today's young alcohol abusers are, in fact, a high risk group for later alcohol problems." And so the cycle of

¹ Milam, Ibid. P. 8

² Dailey, Ibid.

institutionalized drinking continues. It will not do, as some observers have done, to assume that supposedly atypical drinking behavior either prevents alcoholism or produces a different type of alcoholism among Indian or other people. Milam says in this regard:

"Some alcoholics engage in daily maintenance drinking, some drink only on weekends, or only beer, or only wine with meals, etc. The same individual may use a variety of different control strategies during different phases of his illness. All kinds of people become alcoholic and all sorts of cultural, social, psychological, and economic factors contribute to the various styles of drinking and to various levels and strategies of control at different stages of the illness. Those who mistake these psychosocial variables for causes of alcoholism will inevitably make the additional mistake of supposing that there are multiple types of alcoholism."¹

It is crucial for purposes of this study of Indian alcoholism in Montana for both Indian and non-Indian alike to fully understand the etiology of this disease. Data in this study show that the institutionalized pattern of drinking present on and off Montana reservations is directly related to a high incidence of alcoholism. Arguments about periodic binges, ritualistic drinking, etc., which dominate the literature on Indian drinking fail in several important respects to deal directly with what is happening among Montana Indians. Walgren and Barry's work shows conclusively that physical adaptation, tolerance to and dependence on alcohol develop with even small amounts of alcohol among some individuals. Milam summarizes the data from many studies on adaptation, tolerance and dependence

¹ Milam, Ibid. P. 16

with these observations:

"Although seldom fully appreciated by researchers, it is of critical importance to note that widely ranging individual differences are found in all time dose studies of physical adaptation to alcohol. Among both animals and humans some subjects display increased tolerance and physical dependence following only one low dosage trial, while at the other end of the distribution of differences, some subjects do not become physically adapted even after prolonged periods of heavy alcohol dosage. Thus the aggregate of research evidence is fully supportive of the concept of a genetic gradient of susceptibility to alcoholism, revealed in the well known variability in the durations and rates of alcohol ingestion required to precipitate the progressive alcoholic drinking pattern among different individuals and ethnic groups. Again, the psychological, social, and cultural reasons a person drinks are not relevant, and the amount consumed is relevant only in the context of the individual's susceptibility to physical adaptation." ¹

Given the institutionalized pattern of drinking among Montana Indian people and the probability of high susceptibility of adaptation to alcohol resulting in alcoholism, the mysteries surrounding high rates of Indian alcoholism in Montana disappear. The concept of a genetic gradient undoubtedly applies.

It is important to note that discussing variable rates of susceptibility to alcohol adaptation, tolerance and dependence among different individuals and ethnic groups does not imply racist overtones at all. Nor does it imply any "alcoholism gene." What it does imply is that the differentiation among individuals and ethnic groups of resistance to alcohol is great; and, this is directly in line with the research showing great individual

¹ Milam, Ibid. P. 12

differences in all biological tolerances. Summarizing the work of R. J. Williams, Milam points out:

"As described in eloquent detail by Williams (1971), wide individual differences are normally found in every organ and facet of physiology and biochemistry, and in biological tolerance for every common substance that people put in their bodies, including alcohol." ¹

There is, moreover, a preponderance of evidence showing that gradation in tolerances to substances, including alcohol, occur among ethnic groups. The substantial body of evidence suggesting genetic origins of differential rates of susceptibility bears directly on the high rates of alcoholism among American Indians and among Indians in Montana. In his 1972 study of ethnic differences in alcohol sensitivity, P. H. Wolff reported in Science magazine:

"The assumption that ethnic group differences in autonomic regulation have a genetic basis is compatible with other reports of racial differences in autonomic responses to selected pharmacologic agents."

Moreover, these genetic based differential rates among different cultural groups are a world-wide phenomena according to Melzberg's The Alcoholic Psychosis. Not only does the evidence suggest differential rates of susceptibility to alcoholism among ethnic groups, it suggests Indian Americans have both high susceptibility and "early age at onset" of Alcoholism. (See Table VII)

This summation of the probably effects of the genetic contribution to different ethnic group susceptibility to alcoholism can

¹ Milam, Ibid. P. 13

TABLE VII

ALCOHOLISM EPIDEMIOLOGY

<u>Ethnic Group</u>	<u>Estimated Time Exposed</u>	<u>Resistance</u>	<u>Age of Onset</u>	<u>Alcoholism Rate</u>
Jew Italian	Lost in Antiquity	High	Late	Low
Irish North European	1500 years	Medium	Medium	Medium
North American Indian & Eskimo	300 years	Low	Early	High

The time exposed to alcohol refers to the time in each group that alcohol is estimated to have been available in sufficient quantity that significant numbers of the population susceptible to alcoholism could progress in their drinking and deterioration.

From: James P. Milam, The Emergent Comprehensive Concept of Alcoholism.

be extended. Sufficient quantities of alcohol available enabling significant numbers of Montana's Indian population to progress in their drinking and deterioration could not have occurred before 1860. This would mean that Montana Indians, at the most, had sufficient quantities of alcohol available for only 116 years. Moreover, while alcohol was obtainable for both reservation and off-reservation Indians it is notable that legal drinking and, therefore easily available alcohol, for off-reservation adult Indians occurred in 1953, only 24 years ago. Table VIII extends Dr. Milam's concept further to the peculiar case of the Northern Plains and Montana Indian population.

The actual period of time (150 years at most) when Northern Plains Indians had sufficient quantities of alcohol available for widespread use is clearly insufficient to develop the genetic progressions resulting in increased resistance to alcohol found in other ethnic groups using alcohol for a longer time. Moreover, intermarriage with non-Indians by Montana Indian people has been primarily with whites of North European stock who, themselves, have a fairly high rate of alcoholism and a relatively short period of substantial alcohol use. (see Table VIII). That heredity and therefore genetics play a part in susceptibility to alcoholism is clearly shown by research involving identical and fraternal twins, infants born of alcoholic mothers and in studies of enforced alcoholism among mice and subsequent alcoholism among their offspring. Consider the comparisons of Jews, Italians, and the French:

TABLE VIII

ALCOHOLISM EPIDEMIOLOGY (MONTANA REVISION)

<u>Ethnic Group</u>	<u>Estimated Time Exposed</u>	<u>Resistance</u>	<u>Age of Onset</u>	<u>Alcoholism Rate</u>
Jew	Lost in Antiquity	High	Late	Low
Italian				
Irish	1500 years	Medium	Medium	Medium
North European				
North American	300 years	Low	Early	High
Indian & Eskimo				
Montana Indian	150 years	Low	Early	High
Montana Indian Legal Drinking	23 years	Low	Early	High

" . . . The Jews and Italians after more than 15,000 years of exposure have very low susceptibilities and rates of alcoholism, and rates of attrition are also, of course, correspondingly low, Gloor (1952), Moody, and Dubos (1965). Contrary to the belief that mental illness causes or predisposes to alcoholism, it is of considerable interest that the Jews rank lowest among ethnic groups in the United States in alcoholism, while ranking highest in schizophrenia. In a different type of comparison, it is also revealing that the Italians have been exposed to alcohol in quantity for more than ten times as long as the French, and that they have only one-tenth as many alcoholics per capita as the French. These findings are all the more impressive in view of the fact that the Italians drink more alcohol per capita than the French. Which of the two ethnic groups drink more irresponsibly is not proven by this data, but the logic of the situation strongly indicates the Italians. ¹

Both logic and the data support the view of this study that an institutionalized drinking pattern and genetic predisposition combine to produce the explosive alcoholism rate among Montana Indians. The health, accident and socio-legal consequences of this explosion are obvious in any statistical treatment of the data. The human suffering involved has nothing whatever to do with psychological, moral or cultural inadequacies of Indian people. Over 20 years ago E. M. Lemert observed:

"I propose that inebriation need not in all cultures be considered, as it has so often been, as a symptom or an expression of deprivation in personality or of defective social organization. There is an alternative way of viewing drunkenness, which is to say as an institutionalized pattern operating in a relatively autonomous way and only tenuously related to the other aspects of the culture." ²

¹ Milam, Ibid. P. 41

² Lemert, E. M., Alcoholism and Sociocultural Situation, Quarterly Journal, Studies of Alcohol, 1956

Due to the institutionalized drinking pattern and a high genetic susceptibility to alcoholism, the Montana Indian is, unknowingly, the proverbial sitting duck. Becoming and remaining sober in the face of this institutionalized pattern and a high genetic susceptibility requires all the assistance and reinforcement the two cultures can muster.

Treatment and the Two Cultures in Montana

Concluding his historical survey of alcohol and the North American Indian, R. C. Dailey makes this observation:

"At any rate, I do not think we can anticipate an appreciable moderation in the Indians' use of alcohol until one of two things happen; either they rapidly acculturate thereby losing their separate identity in the parent society or they overcome their apathy, define their drinking problem themselves (instead of letting us do it for them) and take steps, probably with our help, to do something about it."¹

The fundamental factor of the Montana Indian's life is that he lives in two cultures -- one white and one Indian, and geographical location within Montana makes no difference. Whether on or off the reservation, life for the Indian exists within two cultures. For the off-reservation Indian, which is the focus of this section of the study, alcoholism treatment is almost totally within the context of the white culture. Interviews with Indian people and Indian alcoholism counselors in Montana indicate that the period of apathy mentioned by Dailey is rapidly expiring. The data from the Missoula Indian study and the effective action on the Salish-

¹ Dailey, Ibid.

Kootenai Reservation and elsewhere also point to the passing of a period of apathy. Unfortunately, however, treatment for off-reservation Indians, who at any given time include substantial numbers of all Montana Indians, is wholly inadequate to the treatment tasks. Because Indian people in Montana exist within two cultures, it is commonplace for members of the majority, non-Indian culture, to ignore or suppress the fact of the minority Indian culture. Consider the following brief facts concerning the Indian presence in Montana:

1. In 1977 there are approximately 50,000 people of Indian descent in Montana.
2. There are seven Indian reservations.
3. Fourteen tribes are represented in Montana.
4. At any given time, roughly half the Indian population are probably at Montana locations off the reservations.
5. More than one out of every 20 Montanans is an Indian.
6. Only 150 years ago more Indians populated Montana than whites.
7. For a large percentage of Indians in Montana, English is a second language.
8. For a larger percentage, two languages are spoken fluently in social groups including the family.
9. Art, religion, value systems, and moral precepts are often quite distinct from those of white Montanans.
10. There has been and still exists prejudice with clear racial overtones between whites and Indians in Montana.

This brief summary does not do justice to drawing distinctions between the Indian and white culture as Indians live it in Montana.

However, it does have some very clear implications for the treatment of alcoholism in the twin cultural context of Montana.

In discussing treatment of Indian alcoholics, the Native American Rehabilitation Association (NARA) of Portland, Oregon went to the core of the problem:

"Admittedly, limited resources do exist to help alcoholics in general. But these limited resources, even when available to Indians, are largely ineffective.

Another problem is that most current programs look upon patients as a confluence of cultures rather than a parallel of cultures. The modality is White. If the Indian is willing to accept that modality and give up his own, treatment progresses. If not, the Indian is abandoned." ¹

Judging from the number of Indians repeating treatment in Montana the Indian is doubtless not abandoned in Montana, but the lack of treatment success thus indicated merely confirms the Oregon group's principal observation. Interviews with Indian and non-Indian alcoholism counselors in Montana also confirm the pertinence of the NARA observation for Montana. However, it would be overstating the case to say that all white treatment modalities in Montana fail for Indians completely. Montana Indians do get and stay sober through treatment groups. In this study, interviews with Indian alcoholism counselors and non-Indian counselors confirm, however, that the numbers are small. From the interviews in this study, it becomes clear that the major contributor to the lack of success of alcoholism treatment of Indian

¹ NARA Narrative: Funding Application, Portland, Oregon, 1976

people in Montana is that following treatment they re-enter the cultural pattern described here as institutionalized drinking. This institutionalized drinking pattern is the product of a great variety of factors including poverty, boredom, stress, tension, desires to socialize, Indian cultural values of sharing and being together, dependence on alcohol itself, friendship, etc., all contributing to or reinforcing the pattern. And, from the point of view of continuing sobriety following treatment for Montana Indian people, very few alternatives are perceived to exist. This situation is not confined to Montana Indian people. In 1975 the Oregon Indian Commission on Alcohol and Drug Abuse reported this finding:

"The treatment of the Indian alcoholic or drug user has so far proved ineffective or occasional. The problem with the treatment, we believe, rests with the fact that even if the Indian is detoxified or dried out, he returns to a situation that demands his continued use of alcohol or drugs." ¹

It is the view of this study that the Montana Indian's situation does not "demand" continued use of alcohol. But, it is recognized that the institutionalized drinking pattern among Montana Indians is a formidable barrier to continued sobriety for them.

Based on research in the alcoholism field, interviews with both Indian and non-Indian alcoholism counselors and others close to Montana's Indian problems, the following aspects of the problem

¹ 1975 State Plan on Alcohol and Drug Abuse; Oregon Indian Commission on Alcohol and Drug Abuse (Stewart L. Castro, Executive Director), 1975, P. 8

are clear. Proposals for treatment of off-reservation Indian alcoholism must address the following four major factors:

1. Alcoholism among off-reservation Indians is rampant and of epidemic proportions in Montana. This situation is the product of two primary forces:
 - a. An institutionalized drinking pattern leading to physical adaptation, tolerance, and dependence upon alcohol.
 - b. A high susceptibility to alcoholism which the evidence suggests is produced by a complex of genetic factors.
2. Indian people live in and are affected by two cultures and treatment modalities are principally grounded in the white culture only. Treatment is effective, therefore, only in the occasional cases where an individual is willing to accept treatment within only one culture -- the white, non-Indian context.
3. Upon termination of treatment, Indian people return to a social and family situation where the institutionalized drinking pattern is a principal, dominating force with little or no reinforcement for sobriety.
4. Lacking understanding of the processes of adaptation to tolerance of, and dependence on alcohol, family and social groups perpetuate the cycle of alcoholism among those already treated for alcoholism, among the young

abusers of alcohol, and among those untreated but active participants in the institutionalized drinking pattern. It is important to note that the origins for the institutionalized drinking pattern are several: poverty, boredom, feelings of hopelessness, exclusion, abandonment, the Indian concept of sharing, dependence on alcohol itself, the anxiety of trying to live in two cultures, and several others.

These four factors, then, should be the basis for planning treatment programs for Montana's Indian people. Repeatedly in interviews with Indian alcoholism counselors during the course of this study, the point has been reiterated that treatment, follow-up, and counseling should recognize that Indian people live both in white and Indian cultures; and particularly in counseling and follow-up treatment, the Indian alcoholic's cultural values should be recognized. A second major point made by Indian counselors is that return to the institutionalized drinking pattern must somehow be interrupted by some system which will reinforce sobriety -- a sober system of socializing that is a clear and workable alternative to the institutionalized drinking system. A third point emphasized by these counselors is that the family, in many cases the extended family, should be a major point of contact for counseling, both for those coming out of treatment and for purposes of education for alcoholism prevention. A fourth point emphasized by these counselors is that

while alcoholism is a problem for all Americans, the severity of the problem among Indian people calls for Indian people to plan for and participate in its solution. That Indian people are sensitive to the problem has, it is hoped, been demonstrated by the data presented in the course of this study.

While these counselors are in universal agreement that there is no such thing as "Indian alcoholism", they do generally agree that treatment and maintenance of sobriety require substantial recognition and employment of Indian cultural values. They point out, not too surprisingly, that the most effective existing follow-up program for non-Indians is an essentially non-Indian program centered on the major values of western white culture -- Alcoholics Anonymous. Moreover, the family in Montana's Indian cultures -- these counselors point out -- is of unique importance traditionally and should be, therefore, an integral part of alcoholism counseling among Indian people. (It should be noted here, incidentally, that Montana Indian families are not as dispersed geographically as is typical among white families.) Additionally, both professional practitioners in the alcoholism treatment field and Alcoholics Anonymous have discovered that family participation in the treatment process is frequently the difference between returning to alcohol and continued sobriety. There has been no widespread use of AA by Montana Indians who have had drinking problems principally for the reasons outlined above. The result is that the family involve-

ment possible in AA is not part of the picture for Indian people attempting to maintain sobriety. At any rate, conventional approaches to treatment, including AA, are successful only in small numbers of cases of Indian alcoholism in Montana. In major part this may be due to the fact that non-Indian approaches, including AA, often require the alcoholic to get deep within himself. In many cases this demands getting at resentments and hostilities which Indian people do not feel they can display in the presence of non-Indians, against whom many of these resentments and hostilities may be directed.¹

One of the most successful treatment programs for Montana Indians is on the Salish Kootenai Reservation. This treatment program and follow-up is not AA oriented. The program includes sub-acute detox, treatment and a half-way house modality that is Indian centered. The most striking part of the program, however, is the major emphasis on family counseling. Without question, according to the director of this program, the family counseling approach is a virtual necessity for successful treatment of the Indian people dealt with in this program. In this program family counseling begins when the client is admitted to detoxification.

¹ This is an observation of the writer reinforced by discussions with James Milam, Ph. D., Director of the Alcenas Center in Kirkland, Washington; and, of course, this observation does not apply to all-Indian AA groups.

Some Recommendations

The following recommendations are principally for off-reservation programs for Indian alcoholism. The emphasis in the course of research for this study has been the off-reservation Montana Indian alcoholism situation, and these recommendations reflect that emphasis. It should be remembered, however, that the mobility of Montana's Indian people to and from the reservation, their location in rural towns, and the relatively small cities which comprise Montana's major urban areas is a considerably different off-reservation situation than, say, Los Angeles or Seattle. The large number and size of Montana reservations, the high mobility of Indian people, the relatively small size of Montana's cities makes hard and fast distinctions between reservation and off-reservation Indian people something of a myth -- a myth, incidentally, often perpetuated by local governments for purposes of economy in dealing with costly social problems.

1. One major recommendation is that agencies dealing with Indian alcoholism recognize that Montana's Indian people are a distinct, unique, cultural minority with traditions, values and even linguistic differences, and that the Indian lives, not necessarily by choice, in two cultures.
2. A second major recommendation follows from the first. Alcoholism treatment for Montana Indian people, and particularly the follow-up portion of treatment, should be centered on these cultural distinctions. Other states,

Oregon for example, have found this to be a more successful approach.

3. A third major recommendation is that those manifestations of Indian culture which could be important to successful treatment be employed. These include, but are not limited to:
 - a. the tradition of the Indian family
 - b. that it is not part of the Indian cultural tradition to use alcohol (It is, after all, a white man's drug in possession of Montana Indian people less than 150 years.)
 - c. Indian people communicate better with members of their own cultural group.
4. Recognize the deep concern Indian people have about alcoholism.

The following specific recommendations to deal with off-reservation Indian alcohol problems are based on the conclusions presented in this study. They represent strategies which appear to be potentially more successful than current undertakings.

1. To intercept the return to the institutionalized drinking pattern Indian people should be treated in major off-reservation locations through a series of Indian centered half-way houses and three-quarter houses.
2. Existing treatment centers treating Montana Indian people should be staffed with Indian counselors whose approach

- would be an Indian cultural orientation for Indian clients.
3. Counseling of the Indian alcoholic's family within the Indian cultural context should be a major emphasis in the Indian treatment modality regardless of location.
 4. Training of Indian alcoholism counselors for placement in specific, available positions utilizing existing Montana Indian training expertise such as that available at the alcoholism center on the Salish-Kootenai Reservation at Ronan.
 5. Utilize the Indian family as the focus for alcoholism prevention education programs. Materials for these programs should include existing multi-media presentations developed specifically for Indian people by the University of Utah Alcoholism Center. These materials should be substantially augmented by the development of education materials specifically for Montana Indian people with a distinctly Montana and contemporary focus. These materials should be multi-media with emphasis on a visual approach.
 6. All follow-up efforts including half-way and three-quarter way houses should be geared to utilizing existing manpower training resources.

CONCLUSION

The description of alcoholism among Montana Indians and recommendations for approaches to deal with the problem are based on interviews mainly, but not exclusively, with Indian people who

have had substantial training and experience in the alcoholism field. References to alcoholism research represent the best available data commensurate with existing scientific evidence. The severely depressed economic and social conditions of Montana Indians undoubtedly contribute to their drinking behavior. In the midst of this country's affluence, some of these conditions defy belief. Nevertheless, this study was concerned with drinking behavior, alcoholism and recommendations for treatment. The alcoholic, Indian or non-Indian, cannot wait for economic and social changes before he is adequately treated because, in the interval, there is a very good chance he will die.

SECTION 9
ACTION PLAN FOR FY 1977

ADMINISTRATION
EVALUATION AND RESEARCH
TRAINING AND EDUCATION
COORDINATION
PREVENTION

GOAL I

- Plan, promote, and assist in the support of alcohol and drug dependence prevention, treatment, and control programs;
- Conduct, sponsor, and support research, investigations, and studies, including evaluation, of all phases of alcohol and drug dependence;
- Assist the development of educational and training programs relative to alcohol and drug dependence, and carry on programs to assist the public, and technical and professional groups, in becoming fully informed about alcohol and drug dependence;
- Promote, develop, and assist financially and otherwise, alcohol and drug dependence programs administered by other state agencies, local government agencies, and private nonprofit organizations and agencies;
- Encourage and promote effective use of facilities, resources, and funds in the planning and conduct of programs and activities for prevention, treatment, and control of alcohol and drug dependence and, in this respect, cooperate with and utilize to the maximum possible extent the resources and services of federal, state, and local agencies.

OBJECTIVE A

To plan, promote, and assist in the support of alcohol and drug dependence prevention, treatment, and control programs.

Course of Action:

1. To ensure the continued funding of State-approved alcohol programs. Availability of funding will be advertised throughout Montana in July, 1977. Local program application and operational plans will be reviewed utilizing the procedure

listed in Accomplishments, Section 7, during September, 1977. Plan approval and grant awards notices mailed week of October 3, 1977.

2. To award a contract(s) for the development of a minimum of 35 residential alcohol beds in Montana Mental Health Region I in October, 1977.
3. To continue to implement the Uniform Alcoholism Act by establishing 10 new detoxification beds in two new detoxification centers in Montana. Contracts for the detoxification centers will be advertized in October and awarded in November, 1977. Centers will be operational for detoxification services January, 1978.
4. To pay the cost for direct detoxification services when alternative private or public support is not available. To reimburse rural law enforcement agencies for transportation services of alcoholics to treatment services. This objective is an ongoing service and will provide service for 150 individuals.
5. To continue regionalization activities as planned in Section 8 regional plans. Regions I and V contracted October 1977 with regional alcohol and drug boards to implement their plans. Contracted Regions II, III and IV to October 1977 with local alcohol provider to implement regional plans and to hold two meetings in each region to discuss common problems and needs assessments prior to July, 1978.
6. To fund a minimum of one Urban Indian Alcohol Treatment program to begin implementation of the urban Indian alcohol plan.

Advertise funding October 1977. Contract November, 1977 and monitor through the Division MIS system results of program.

OBJECTIVE B

To conduct, sponsor, and support research, investigations, and studies, including evaluation, of all phases of alcohol and drug dependence.

Course of Action:

1. To evaluate every alcohol program that is currently State-approved. There are currently 20 approved programs and we estimate it will be necessary to perform 10 follow-up evaluations, prior to July 1978 conduct 30 on-site program evaluations.
2. To evaluate all agencies and programs requesting State-approval. In July, 1977 we have 10 requests for approval and expect each evaluation will require a follow-up evaluation; prior to July, 1978 conduct 20 new program on-site evaluations.
3. To review the handbook used for alcohol program evaluations and redevelop sections not meeting the state and local program needs January, 1978.
4. To complete pilot of alcohol management information system July, 1977.
5. To revise and implement the alcohol MIS October, 1977.
6. To implement and maintain the alcohol MIS system November-July, 1978.
7. To contract for detailed studies of specific uniform act implementation problems.

- a. Study protective custody procedures.

The Alcohol and Drug Abuse Division will fund a definitive study on the entire question of protective custody - its nature, intent, and use.

- b. Study the vulnerability of officers who deal with public inebriates.

The Alcohol and Drug Abuse Division will cooperate with LEAA and other Law Enforcement agencies to develop model implementation guidelines for the use of police and sheriffs departments.

- c. Study and document the use of substitute charges.

The Alcohol and Drug Abuse Division will fund a study to investigate and document the nature and use of substitute charges to circumvent the decriminalization provisions of the Montana Uniform Act.

Contract(s) will be advertised and awarded in October, 1977 with a completion date of May, 1978.

8. To utilize the alcohol MIS and national reporting systems and data to establish a more exact number of alcoholics and people impacted by alcohol in Montana, June, 1978.
9. To develop and support a local, regional and statewide task force to establish the unique problems faced by women alcoholics and develop a treatment modality that will respond to identified needs. Develop the state level task force using the female members of the Advisory Council as a nucleus in October, 1977. Assist the task force in development of their plans and priorities of task implementation; final task force report to be received in May, 1978.

10. To cooperatively fund and implement with the Montana Department of Social and Rehabilitation Services a program to plan, design and offer to state and federal governments a proposal for addressing the problem of alcohol abuse among Montana youth. The program will involve youth organized on a regional level who will meet once as a statewide task force. The aim of the plan will not be to eliminate the drinking of alcoholic beverages, but rather to teach the basics of responsible drinking and to encourage youth to analyze why they drink and what the alternatives are. Final report will be submitted to the Alcohol and Drug Abuse Division June, 1978.

OBJECTIVE C

To assist the development of educational and training programs relative to alcohol and drug dependence, and carry on programs to assist the public, and technical and professional groups, in becoming fully informed about alcohol and drug dependence.

Course of Action:

1. To implement an alcohol counselor certification system at a Class II level. We believe certification to be both the beginning and end of the training system. In August, 1977 to file and publish the alcohol certification system. Conduct one hearing in each of the five regions to obtain public input into the proposed certification standards August-September, 1977. Review and act on citizen input to certification September, 1977. Publish final certification standards and implement alcohol counselor Class II certification in October, 1977.

2. To provide the necessary training for all alcohol counselors now employed to meet certification. Provide 48 training session for 871 trainees by July, 1978.
3. To provide training for alcohol program administrators in use of Class II, III and IV levels, provide two training sessions before July, 1978.
4. To fund and operate the Montana School for Alcohol studies in June 1977. The school will be advertised to all institutions of higher education in the state for co-sponsorship. The school itself will last 3-5 days, serving 500 individuals (not counted above), will feature at least one nationally known figure in the alcohol field, and will include the latest research in the field of alcoholism. Curriculum will be developed only after evaluation material completely analyzed from 1977 school.
5. To assist in the planning, development and funding of a pilot alcohol education seminar in cooperation with the University of Montana and Montana Committee on Humanities. The alcohol seminars will be held in five rural Montana communities, for 1½ days, and will deal with societies view of alcohol, the stigma of alcoholism, methods of counseling and what is AA. Project will involve 100 residents and take place September-December, 1977.
6. To provide technical assistance on-site to a minimum of 30 alcohol treatment programs July, 1978.
7. To implement a uniform client record keeping system for Montana by January, 1978.

OBJECTIVE D

To promote, develop, and assist financially and otherwise, alcohol and drug dependence programs administered by other state agencies, local government agencies, and private nonprofit organizations and agencies.

Course of Action:

1. To cooperately plan, develop and fund with the Department of Justice one substance abuse counselor at Pine Hills School, Swan River Youth Forest Camp, and Montana State Prison. The positions will be advertised in August, 1977, and substance abuse counselors begin work September, 1977.
2. To cooperatively evaluate seven Indian reservation alcohol treatment programs with representatives of Indian Health Service.
3. To establish monthly meetings at a state level with all agencies that effect or are affected by alcoholism. Meeting will start in October, 1977 and be ongoing.

OBJECTIVE E

To encourage and promote effective use of facilities, resources, and funds in the planning and conduct of programs and activities for prevention, treatment, and control of alcohol and drug dependence and, in this respect, cooperate with and utilize to the maximum possible extent the resources and services of federal, state, and local agencies.

Course of Action:

1. To develop an alcoholism prevention system that meets Montana's needs. October-December, 1977 develop a comprehensive prevention

plan and implement plan January-July, 1978. Report results of prevention plan in FY78 state plan.

2. To cooperate with Highway Patrol, Department of Justice, Highway Safety Division, Department of Community Affairs in developing and implementing a DWI Program. The Highway Safety Division will contract with the Alcohol and Drug Abuse Division to and develop the DWI curriculum October, 1977, train three DWI core trainers November, 1977 and certify 30 DWI counselors by July, 1978.
3. To develop with the Department of Justice a feasibility study to establish sub-acute detox facilities in rural Montana jails.
4. To continue to administer the State Employee Assistance Program (ongoing); and to provide a list of available employee assistance services in the state telephone directory by June, 1978.

SECTION 10

SUMMARY BUDGET

FEDERAL FORMULA BUDGET

STATE LEVEL BUDGET

COUNTY LEVEL BUDGETS

HB627 FUND DISBURSEMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

STATE Montana 1977

AGENCY Department of Institutions

☒ INITIAL
☐ REVISION NO. _____

STATE HEALTH PLAN BUDGET

FUND SOURCE	TITLE V-SOC. SECURITY ACT		PUBLIC HEALTH SERVICE ACT, AS AMENDED					
	SEC. 503 WCH	SEC. 604 CC	SEC. 314(j) PLANNING	SEC. 314(i) PUBLIC HEALTH	SEC. 314(d) MENTAL HEALTH	SEC. 303(a) ALCOHOL	SEC. 303(a) MH CONST.	SEC. 603(d) HOSP. ADMIN.
1. STATE PUBLIC	A	B	C	D	E	F	G	H
2. LOCAL PUBLIC						2,217,549*		
3. PRIVATE NON-PROFIT						1,390,000**		
4. SUB-TOTALS						3,607,549		
5. FEDERAL	FINANCIAL ASSISTANCE	FUND A				200,000		
	DIRECT ASSISTANCE	FUND B						
6. PREVIOUS FISCAL YEAR (H) CARRYOVER	A.							
	B.							
7. TOTALS						3,807,549		
8. NON-FEDERAL SHARE REQUIREMENTS								
9. MAINTENANCE OF EFFORT						593,227		
10. AMOUNT OF MATCHING PROPOSED BY STATE								
11. DIRECT COMMUNITY SERVICES								
12. TOTAL HEALTH FUNDS BUDGETED						3,807,549		

PROGRAM DIRECTOR (Name and Title)

Michael A. Murray, Administrator, Alcohol & Drug Abuse Division
AGENCY HEAD (Signature) Lawrence M. Zanto 7/20/77

TITLE Director, Department of Institutions
OFFICE OF GOVERNOR
TITLE _____

* Based on estimate of funds available as authorized by HB627; also includes \$23,123 general fund money for administration.
** Based on estimate of funds available to local governments as authorized by HB627 and other local funds, also includes \$190,000 Federal Incentive Grant.

Federal formula funds will be utilized as follows:

1.	Continue regionalization implementing regional plans.	\$110,000
2.	Alcohol and Drug Abuse Division to implement alcohol MIS.	20,000
3.	Fund Urban Indian Alcohol Programs.	30,000
4.	Women needs task force and research.	10,000
5.	Youth issue task force.	7,500
6.	Develop and implement Alcohol Prevention Education System.	<u>22,500</u>
		\$200,000

State Alcohol Tax Funding

New tax will generate approximately 2.2 million dollars for use and distribution by the Alcohol and Drug Abuse Division as follows:

1.	Galen State Hospital/Alcohol Treatment and Rehabilitation Program.	\$1,000,000
2.	Alcohol and Drug Abuse Division.	200,000
3.	Eastern Montana Residential Treatment Program.	400,000
4.	Current level continuation of State-approved alcohol Programs (July-October 31, 1977).	400,000
5.	Support of State-approved programs and funding new programs.	<u>200,000</u>
		\$2,200,000

County governments will receive an estimated 1.1 million dollars
ear marked for alcohol treatment as follows:

	<u>FY'78</u>	<u>FY'79</u>
Beaverhead	\$ 14,245	\$ 14,955
Big Horn	10,922	11,466
Blaine	9,598	10,076
Broadwater	4,241	4,452
Carbon	12,730	13,364
Carter	2,058	2,160
Cascade	132,507	139,204
Chouteau	8,417	8,836
Custer	21,695	22,774
Daniels	4,600	4,830
Dawson	13,370	14,036
Deer Lodge	23,374	24,538
Fallon	5,282	5,545
Fergus	16,250	17,059
Flathead	75,819	79,574
Gallatin	58,683	61,604
Garfield	1,886	1,980
Glacier	22,302	23,412
Golden Valley	898	943
Granite	4,107	4,311
Hill	26,381	27,694
Jefferson	7,175	7,532
Judith Basin	3,370	3,538
Lake	22,754	23,886
Lewis and Clark	69,234	72,681
Liberty	2,856	2,998
Lincoln	21,085	22,135
Madison	8,994	9,441
McCone	3,054	3,206
Meagher	3,780	3,968
Mineral	7,292	7,655
Missoula	108,596	114,001
Musselshell	6,133	6,438
Park	19,908	20,899
Petroleum	550	577
Phillips	8,202	8,610
Pondera	9,426	9,895
Powder River	2,629	2,760
Powell	9,476	9,948
Prairie	1,835	1,843
Ravalli	21,200	22,256
Richland	12,883	13,524

	<u>FY'78</u>	<u>FY'79</u>
Roosevelt	\$ 17,996	\$ 18,891
Rosebud	13,838	14,527
Sanders	11,258	11,818
Sheridan	10,554	11,808
Silver Bow	74,653	78,369
Stillwater	6,845	7,186
Sweet Grass	5,655	5,937
Teton	7,141	7,496
Toole	10,371	10,887
Treasure	1,331	1,298
Valley	15,466	16,236
Wheatland	4,879	5,121
Wibaux	1,881	1,975
Yellowstone	<u>157,821</u>	<u>165,677</u>
 TOTAL	 \$1,159,486	 \$1,217,204

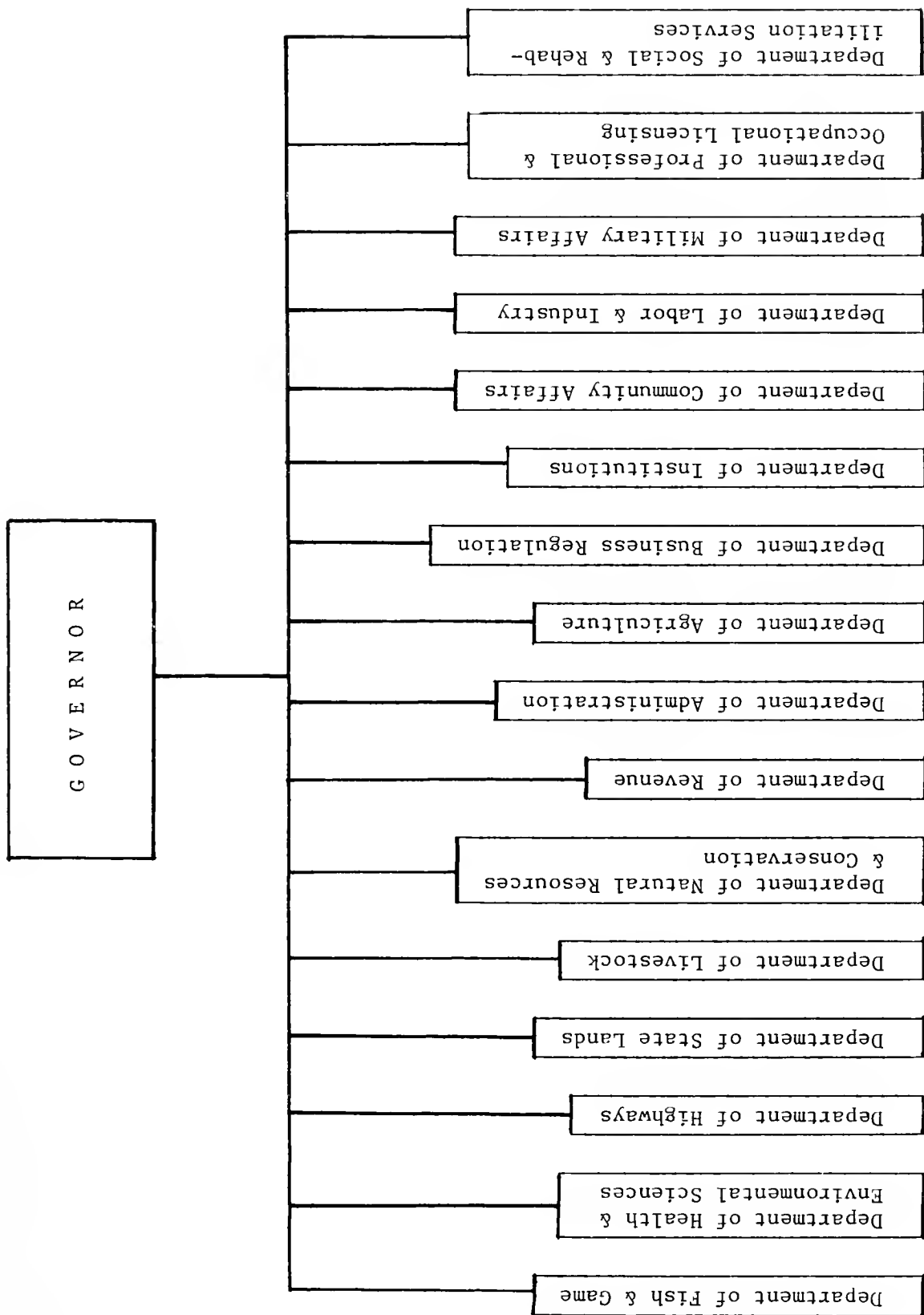
Contract Number	Contract Date	Program	State Contract FY 77	State Contract FY 78 (Same as 5)	Interim Contract 7/77-10/77	State Contract 11/77-6/78	TOTAL STATE Contract FY 78	Requested		Staff Recommendation		Adv. Council Rec.		Approval	
								State FY 78	Total FY 78	State FY 78	Total FY 78	State FY 78	Total FY 78	State	Total
		Hill-Top Recovery	77,535 -	108,385 -	45,937 -	62,448 -	108,385 -	62,448 -	131,795 -	62,448 -	131,795 -	62,448 -	131,795 -		
		Blackfoot Alcohol	12,925 -	27,544 -	3,334 -	24,210 -	27,544 -	35,846 -	139,216 -	13,130 -	116,500 -	14,210 -	117,510 -		
		Cascade City-County	153,000 -	75,719 -	75,719 -	0 -	75,719 -	176,515 -	349,422 -	0 -	173,281 -	0 -	173,281 -		
		Fort Belknap	0,000 -	13,094 -	3,730 -	9,364 -	13,094 -	29,723 -	118,090 -	9,364 -	127,454 -	9,364 -	127,454 -		
		SW MI & Alcohol Serv.	64,600 -	49,184 -	49,184 -	0 -	49,184 -	19,890 -	303,622 -	0 -	283,732 -	0 -	283,732 -		
		Park County	0 -	14,820 -	0 -	14,820 -	14,820 -	20,837 -	34,839 -	14,820 -	33,820 -	0 -	33,820 -		
		Lewis & Clark Alcohol.	6739 -	0 -	0 -	0 -	0 -	12,569 -	93,639 -	11,035 -	89,495 -	0 -	89,495 -		
		Anacosta/Dixie Lodge Co.	8,000 -	30,273 -	8,229 -	22,044 -	30,273 -	20,455 -	4,573 -	4,573 -	22,046 -	0 -	22,046 -		
		Powell County	14,400 -	26,498 -	7,159 -	19,339 -	26,498 -	19,648 -	26,417 -	19,339 -	26,446 -	19,339 -	26,446 -		
		Butte Indian Alcohol	2,281 -	2,000 -	0 -	2,000 -	2,000 -	30,350 -	75,103 -	0 -	44,753 -	2,000 -	42,385 -		
		GEDS - Missoula	0 -	0 -	0 -	0 -	0 -	141,173 -	195,668 -	0 -	0 -	0 -	0 -		
		Lincoln County - Libby	19,294 -	52,701 -	16,053 -	36,648 -	52,701 -	57,594 -	59,109 -	36,649 -	57,174 -	36,649 -	59,174 -		
		McLain General Hosp.	0 -	0 -	0 -	0 -	0 -	0 -	212,890 -	0 -	212,890 -	0 -	212,890 -		
		Sawyers County	0 -	14,168 -	0 -	14,168 -	14,168 -	22,238 -	30,560 -	14,735 -	23,133 -	14,168 -	25,133 -		
		W HI Regional Alcohol	29,631 -	16,970 -	16,970 -	0 -	16,970 -	16,700 -	90,878 -	0 -	61,016 -	0 -	61,016 -		
		Missoula County						3,000 -	16,165 -	73 -	13,931 -				
		Mineral County						13,948 -	36,079 -	5,116 -	25,130 -				
		Ravalli County	0 -	13,948 -	0 -	13,948 -	13,948 -	17,454 -	324,052 -	0 -	306,598 -	0 -	306,598 -		
		Flathead Res. Alcohol	14,225 -	8,640 -	8,640 -	0 -	8,640 -	19,330 -	106,160 -	850 -	75,400 -	11,203 -	69,600 -		
		Missoula Indian Alc.&Dr.	0 -	11,303 -	0 -	11,303 -	11,303 -	78,899 -	235,011 -	0 -	234,526 -	0 -	234,526 -		
		NI MT Alc.& Drug - Kal.	50,504 -	41,819 -	32,215 -	9,604 -	41,819 -								

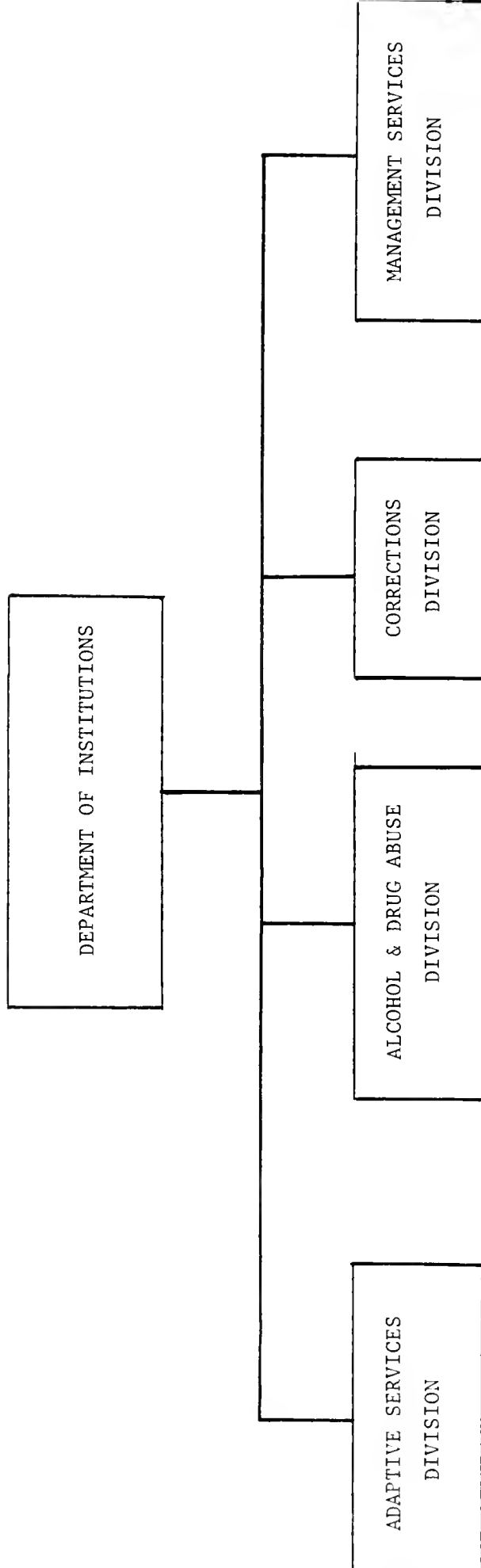
Contract Complete Date	Program	State Contract FY '77	Contract FY '78 (State as 5)	Interim Contract 7/77-10/77	State Contract 11/77-6/78	TOTAL STATE CONTRACT FY '78	Requested State FY '78	Requested Total FY '78	Staff Recommendation FY '78	Staff Recommendation Total FY '78	Adv. Council Rec. State FY '78	Adv. Council Rec. Total FY '78	Approved State	Approved Total
	District I - Glasgow	54,783-	51,452-	22,491-	24,062-	51,452-	35,191-	67,794-	24,062-	66,673-	24,062-	66,673-		
	District II - Glenelvie	30,000-	27,663-	11,495-	14,180-	27,663-	11,942-	52,412-	11,942-	52,412-	16,170-	56,630-		
	Tri-County - Baker	2,474-	2,854-	-0-	2,854-	2,854-	2,514-	15,722-	2,854-	15,351-	2,854-	15,331-		
	Rosebud County - Forsyth	8,633-	-0-	-0-	4,107-	-0-	5,107-	20,225-	5,107-	20,225-	5,107-	20,275-		
	Ouster Co. - Miles City	11,702-	-0-	-0-	-0-	-0-	-0-	20,987-	-0-	20,987-	-0-	20,897-		
	Fort Peck Tribal Alc.	10,019-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-		
	F.M. Deaconess -Glasgow													
	Billings Deaconess	45,400-	-0-		-0-	-0-	-0-							
	Runnicks Guidance Found.	101,284-		100,000-			220,500-	877,491-						
	Central MT Fam. Serv.	-0-	17,650-		17,650-		20,850-	40,740-	20,850-	41,740-	15,966-	36,402-		
	Crow Tribal Alcohol	10,000-	3,340-	3,340-	-0-	3,340-								
	Northern Cheyenne	-0-	20,841-	-0-	-0-	-0-	48,274-	152,705-	26,844-	131,272-	26,844-			
	Wheatland Co. Foundation	-0-	25,922-	-0-	25,922-									
	Musselshell Co. Foundation	-0-	12,785-	-0-	17,785-									
	Golden Valley Co. Foundation	-0-	11,402-	-0-	11,402-									
	Sweet Grass Co. Foundation	-0-	19,316-	-0-	19,316-									
	Stillwater Addictive Dis.	-0-	21,343-	-0-	21,342-									
	Carbon Co. Community Serv.	-0-	17,537-	-0-	17,537-									

SECTION 11

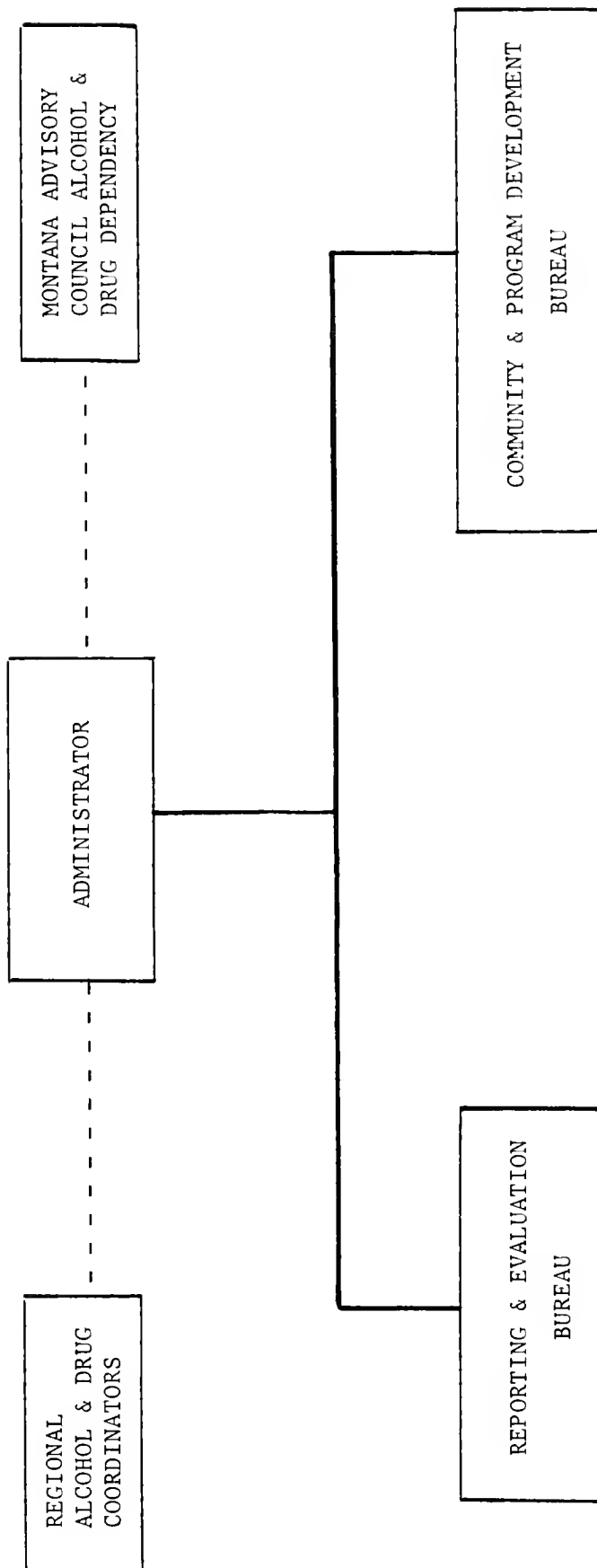
ORGANIZATION CHARTS

ADMINISTRATOR AND BUREAU CHIEFS RESUMES



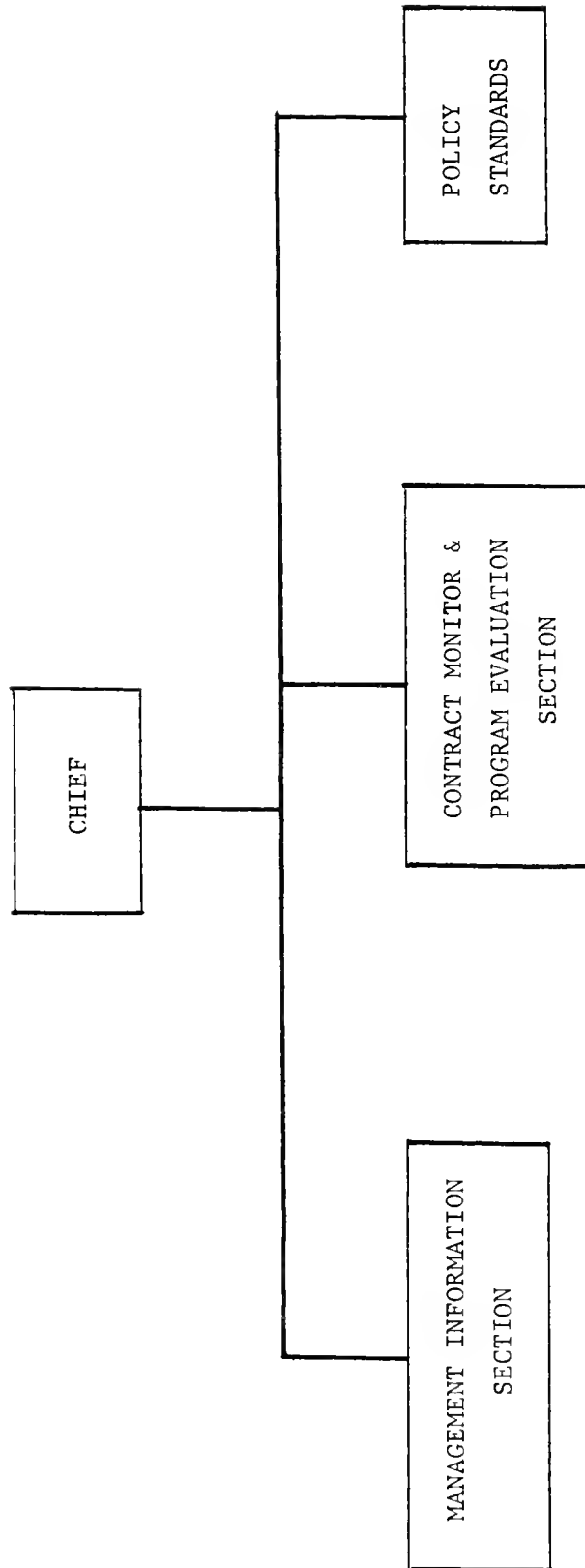


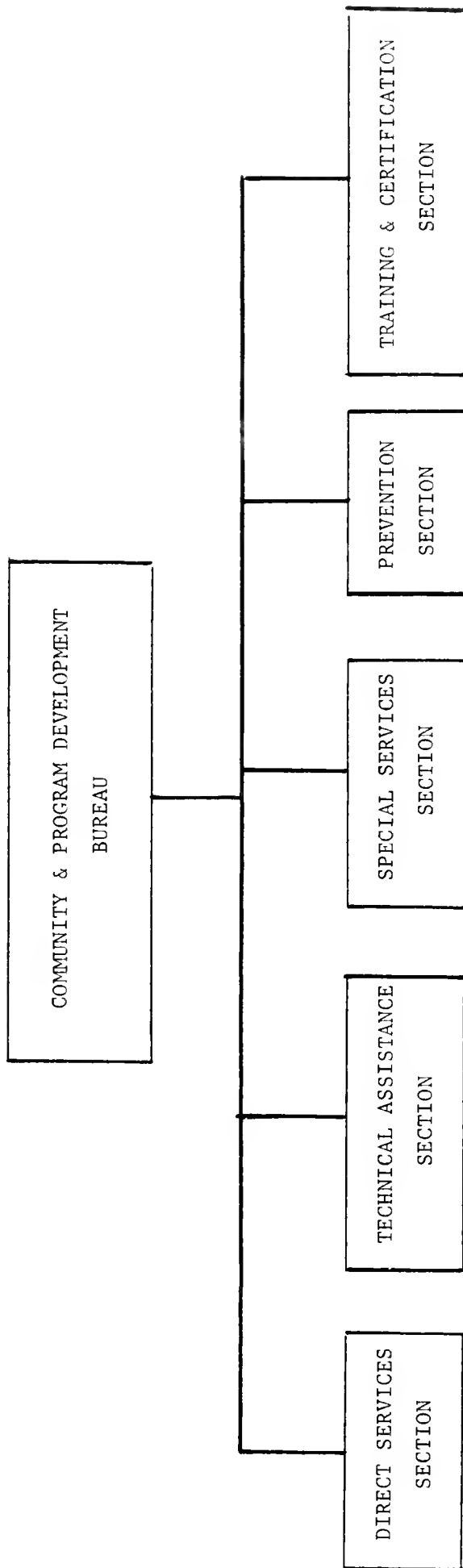
ALCOHOL & DRUG ABUSE DIVISION



REPORTING & EVALUATION

BUREAU





PROFESSIONAL RESUME

OF

Michael Anthony Murray
607 West Lawrence
Helena, Montana 59601

I. Personal Characteristics:

Born September 29, 1941, to Roger and Opal Murray
Father died 1955
Mother retired
Honorable Discharge, U.S. Army Reserve, 1966

II. Family Status:

Married Helena Cronin August 1964
Son - Michael
Daughters - Maura, Jennifer

III. Education:

- a. St. Helena Grade School, Helena, Montana - 1946-1955
- b. Cathedral High School, Helena, Montana - 1955-1959
- c. Carroll College, Helena, Montana - 1960-1964
Graduated with Bachelor of Arts
Dual major in English and History
Dual minor in Philosophy and Education
- d. Nevada Southern University, Las Vegas, Nevada - 1964-1965
9 hours Guidance and Counseling
- e. University of Montana, Missoula, Montana - 1967-1970
17 hours graduate credit with a Psychology emphasis

IV. Experience:

- a. 1956-1960 - Part-time work: Laundry and dry cleaning plant, restaurant as bus boy and waiter.
- b. 1960-1964 - Summers - U.S. Forest Service - Engineering Survey crew boss, Helena, Montana.
- c. 1961-1964 - Winters - Capri Lounge, Helena, Montana - bartender.
- d. 1964-1965 - Gorman High School, Las Vegas, Nevada - Teacher-Coach.

- e. 1965-1967 - Montana State Prison, Deer Lodge, Montana - Teacher-Curriculum Director and Assistant Director of Education. At the prison, I established the curriculum for adult basic education and started a program of college extension for inmates through the University of Montana at Missoula.
- f. 1967-1972 - Rocky Mountain Development Council Inc.; Helena, Montana.

Executive Director of the agency with overall responsibility for operation of the agency. I had a staff of 128 people working with me. The Rocky Mountain Development Council is a Community Action Agency funded for 1.4 million dollars serving Broadwater, Jefferson and Lewis and Clark counties.

I started my employment with the RMDC as Director of Head Start and was promoted to Deputy Director of the Agency in July, 1968. I was promoted to acting Executive Director in August, 1969 and received full authority of the position in October, 1969.

- g. 1972-1973 - Southwestern Areawide Comprehensive Health Planning Council, Inc.; Helena, Montana.

Employed as the Health Planner for a four county area: Lewis and Clark, Jefferson, Broadwater and Meagher. The duties in this position consisted of formulation of a Comprehensive Health Plan and implementation of the plan. In my position, I completed a manual of all Health and Social Services resources for the Helena area, worked with the White Sulphur Springs community on development of a new nursing home, assisted Jefferson County on a rural nurse project, and have written several grants for city and counties pertaining to health.

- h. 1973-1975 - Southwestern Montana Drug Program, Department of Institutions, Helena, Montana.

Administrative Director of this drug treatment and rehabilitation program. Duties include: Plan, organize, assign and evaluate the work of the program's 32 staff members in the treatment and rehabilitation of clients (310 static matrix) within the drug program; supervise contractual agreements with affiliates of the drug program. Directed and coordinated all staff services such as office management, purchasing, accounting, records management budgeting, personnel administration and community relations.

- i. 1975-1977 - Addictive Diseases Bureau, Department of Institutions, Helena, Montana.

Chief of the Bureau; responsible for coordinating all alcohol and drug services in the State of Montana.

RESUME

Robert W. Anderson
304 S. California
Helena, Montana 59601

Personal Data

Marital Status: Married
Wife: Donna
Daughter: Gina
Son: Robert

Height: 5'9"
Weight: 165
Date and Place of Birth: Helena, Montana 6/2/45
Health: Excellent
Disabilities: None

Education

Helena Senior High School, 1963 Graduate
University of Montana, Missoula, BA Degree, Sociology, 1967
Williams AFB, Arizona, USAF Pilot Training, Graduate 1969
Tyndall AFB, Florida, USAF Instructor Pilot Training, Graduate 1969

Licenses and Non-Academic Vitae

FAA Pilot License
Instrument Rating
Commercial Rating
1875 hrs. multi-engine Jet (T-38 and T-37)
60 hrs. Single Engine Propellar (Cesna 150-172)
Master Certificate of Instructor Flying USAF 6/71
USAF Commendation Medal for Meritous Service May 8, 1973
Personnel Mangement Course - DRTC, Civil Service Commission
State Classification Seminar - 11/73
Labor Relations Seminar - 12/73, 3/74
Supervisory Workshop - 5/74
Drug Abuse Single State Core Course - 11/74
Drug and Alcohol Abuse Reporting Workshops - 10/74, 12/74, 4/75, 8/75,
6/76, 11/76, 2/77

Work Experience:

July, 1975 - Present

Department of Institutions
Alcohol and Drug Division
Chief, Reporting & Evaluation Bureau

Responsible for the management and administration of the Reporting and Evaluation Bureau of the Alcohol and Drug Division.

1. Reporting Section - Design, develop, implement and manage alcohol and drug reporting and management information system for all alcohol and drug programs within the State of Montana. Develop and research data for Federal, State, and local program management.
2. Evaluation Section - Design, develop, and manage evaluation and approval standards for State alcohol and drug programs. Conduct on-site program visits to evaluate program efficiency and compliance with Federal and State laws. Develop written reports for management and continually monitor contract compliance.

September 1974 - June 1975 -

Office of the Governor
Addictive Diseases, Unit Program Manager

Responsible for the implementation, management and administration of a State-wide Integrated Drug Abuse Reporting Process. Determined and developed the number, type, frequency and distribution of reports to be generated for State level program management. Developed training plans for community based treatment personnel, field representatives, local coordinators, and selected office staff for implementation of the reporting system. Established and scheduled on-site training sessions. Managed data flow and resolved problems regarding the data. Continually assessed and modified the overall reporting system. Established and maintained a quality control and checking procedure to verify data and pinpoint deficiencies. Assisted State drug programs in meeting reporting standards. Produced output reports for programs. Developed and maintained office and program records. Assisted in the development of a Drug Abuse Training System. Developed and edited a bi-monthly Drug Abuse Newsletter.

July 1973 - September 1974

Department of Revenue, Personnel Officer

Responsible for all Personnel functions within the Department of Revenue. Interviewed all applicants for professional and nonprofessional employment. Collected and screened applicants for hiring officials and conferred with them on approval of employment. Responsible for recruitment, classification, wage and salary development. Advised operating supervisors and officials on rules, regulations, promotions, demotions, transfers and other personnel practices. Compiled and maintained employees' fringe benefit records such as group health insurance and sick and annual leave. Advised and informed employees on all Personnel matters. Developed employee manuals, newsletter, booklets, and other informational materials.

September 1971 - May 1973

Laughlin AFB, Texas 3646 Maintenance
USAF Functional Check Flight Pilot

Test flew and checked out T-37 and T-38 aircraft to determine air worthiness and operational safety following major maintenance and repair work. Also responsible for personnel records, flight scheduling within the Functional Check Flight Section.

August 1969 - September 1971

Laughlin AFB Texas, 3646
Pilot Training Squadron
Instructor Pilot

Instructed student pilots in the advanced phase of the USAF pilot Training Program. Also performed duties as Flight Standardization Officer responsible for the maintenance and standardization of all student flying and personnel records within the flight. Counseled students having problems in flying skills or academic ability, and made recommendations to Flight Commander - counseled students in personal problems which could affect student's performance on flying safety and made recommendations for solutions. Served as Flight Scheduling Officer and scheduled all training flight within the flight.

1963 - 1960

Montana Highway Department
Materials Division
Lab Technician

Conducted soil and concrete tests. Summer work while attending college.

1960 - 1968

Anderson Clothing Company
Clerk

Sold men's clothes and helped with bookkeeping. Periodically did this work while attending high school and college.

George L. Swartz
926 Sierra Rd. W.
Helena, Montana 59601

Born: 11/4/37 - Jordan, Montana

Marital Status: married - 4 children

Military Service: U.S. Navy, 4 years active duty, 1958-1962
Honorable Discharge 1964 - Aviation
Electronics Technician 2nd Class

Education:

Jefferson County High School
Boulder, Montana General - Diploma 1956

Carroll College
Helena, Montana Pre-Med 1956-1957

Montana State University
Bozeman, Montana Education - B.S. 1965

Montana State University
Bozeman, Montana Counseling - M.Ed. 1969

University of Montana Education - 1972

Utah State - San Jose State Tech. of Instru. Dev. 1972

American Management Association Management Certificate

Professional Membership:

Phi Delta Kappa
Vice Chairman of the Board of Directors, National
Association of State Drug Abuse Program Coordinators
Chairman of the Rural Drug Abuse Problems Committee

Experience:

- various summer jobs

1958 - 1962 - U.S. Navy

1965 - 1967 - Montana State University - Resident Supervisor -
Resident Halls

1967 - 1968 - Summers - Boulder River School and Hospital -
Rehabilitation Counselor & Teacher

1967 - 1969 - Whitehall Public - Counselor and Assistant Principal
1969 - 1971 - Shelby Public Schools - Counselor
1971 - Office of Supt. of Public Instruction - Drug Education
Consultant
1971 - 1973 - Office of Supt. Of Public Instruction - Drug Education
Supervisor
1973 - 1974 - Addictive Diseases Unit - Office of the Governor -
Assistant to Drug Coordinator
1974 - 1975 - Addictive Diseases Unit - Office of the Governor -
Drug Coordinator
1975 - present - Department of Institutions - Alcohol and Drug
Division - Chief

Publications:

Curriculum Guide for Drug Education 7-12.

Community Activities:

Active in the YMCA especially in the Y Indian Guide Program in which
he presently directs.

